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Unlocking the Closet Door: Protecting Children from Involuntary Civil Commitment Because of Their Sexual Orientation[†]

by
MIYE A. GOISHI^{*}

Dear Jill:

I'm 15 and I think I'm gay. I'm really depressed about it. I've even thought about suicide sometimes. There's nobody I can talk to. I hate everybody at school. Everybody calls me "faggot." I've gotten beaten up a few times. Don't tell me to talk to my parents. I think they already know and are planning to take me to a hospital to get "cured." What can I do?

Signed,

Desperate¹

This Article assesses how appropriately and effectively the legal system responds to the potential commitment process faced by the adolescent writing this letter.² When a parent decides to admit a child for inpa-

[†] This paper draws upon a presentation at the *Hastings Law Journal* Symposium, *Intersections: The Legal & Social Construction of Sexual Orientation* held on March 29, 1997.

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1. This is a fictionalized letter to an advice columnist. Excerpts from possible responses to this adolescent's letter will be interspersed throughout this Article.

2. There is no good statistical data reflecting how many children face parental commitment because of their sexual orientation. Shannon Minter, staff attorney for the National Center on Lesbian Rights, believes that the problem is not uncommon. He receives an average of two to three calls per month from gay, lesbian, bisexual, transgender or questioning children who have been threatened with or experienced institutionalization by their parents. Interview

tient treatment at a mental hospital, many interests are implicated, with none so vital as the child's interest in avoiding such an extreme loss of freedom. This Article considers the particular vulnerability of gay, lesbian, bisexual, transgender, and questioning³ youth in the commitment process.

Part I summarizes the key holdings of *Parham v. J.R.*⁴ and *In re Roger S.*,⁵ the seminal United States Supreme Court and California Supreme Court decisions delimiting the due process protections afforded to children who face commitment. In addition, it discusses California's anomalous county-by-county implementation of *Roger S.*, as well as the differing rights applying to public and private inpatient mental facilities.

Part II begins by discussing two premises. First, we live in an age in which society's attitudes about its gay members are ambivalent and in flux. Second, the way children in general are treated under the law is also in flux and inconsistent. Part II asserts that, in light of the fact that commitment of children due to sexual orientation implicates both of these premises, the commitment process deserves careful examination. With this in mind, Part II revisits the basic assumptions made in *Parham* and *Roger S.*, with a focus on gay youth.

with Shannon Minter, staff attorney for the National Center on Lesbian Rights, in San Francisco, Cal. (Dec. 3, 1997). Lyn Duff, who was institutionalized and whose story is recounted below, stated that about half of the 80 children at the psychiatric facility where she was placed "had issues of sexual identity." See *infra* notes 196-97 and accompanying text. See also references to anecdotal reports *infra* note 193.

"Many gay and lesbian youth are still encouraged to 'change' their identities while being forced into therapy and mental hospitals under the guise of 'treatment.'" Paul Gibson, *Gay Male and Lesbian Youth*, in U.S. DEPT. HEALTH & HUM. SERV., 3 PREVENTION AND INTERVENTIONS IN YOUTH SUICIDE (Marcia R. Feinleib ed., 1989), reprinted in DEATH BY DENIAL 15, 21 (Gary Remafedi ed., 1994).

The term "commitment" is used to connote involuntary psychiatric inpatient admissions. When parents admit their children for inpatient care, the admission is deemed to be voluntary from the state's point of view, as the child's wishes are generally not considered. For the psychiatric inpatient admissions considered here, where a motivating factor is the parents' concern about, disapproval of or vehement opposition to their child's sexual orientation, it is highly likely that the child does not wish to receive "treatment" to alter his or her sexual orientation. Thus, I am using the term "commitment" to highlight the coercive nature of the psychiatric inpatient admissions based upon sexual orientation. The term "institutionalization" refers to long-term psychiatric inpatient care.

3. There is no commonly used term to refer collectively to gay, lesbian, bisexual, transgender, and questioning persons. None of the alternatives is perfect, but I have opted to use the term "gay" as a collective, all-inclusive term.

Some may not be familiar with the term "transgender." Transgender is meant to include "those who desire to change their gender, are in the process of changing their gender, or have completed the process of changing their gender." See Chai R. Feldblum, *Sexual Orientation, Morality, and the Law: Devlin Revisited*, 57 U. PITT. L. REV. 237, 237 n.1 (1996).

4. 442 U.S. 584 (1979).

5. 569 P.2d 1286 (Cal. 1977).

Finally, Part III proposes changes which will prevent or curtail abuse of the commitment process and will extend protections for the vulnerable and societally marginalized population of gay youth. These proposals suggest a broad range of solutions, beginning with strengthening the admission standard employed for inpatient treatment of minors. Additional procedural protections are recommended. Finally, enforcement of current laws and additional research must occur so that future decisions can be made in an informed manner.

I. Existing Law and Procedures: Inconsistent Standards and Protections

Dear Desperate:

As a fifteen-year-old in California, you have some protections under the law. If your parents decide to admit you to an inpatient mental hospital in California, you have the right to "protest" this decision. If the hospital is public, and you are fourteen or older, you have the right to request a hearing. This hearing must be held prior to admission (but not necessarily in front of a judge) and you have the right to be represented by an attorney. If the hospital is private, you have the right to have an independent clinical review of the decision to admit you, to be conducted within five days of your request, but you don't have the right to representation. If the facility is out-of-state, you are not protected by California law.

A. California's Lanterman-Petris-Short Act

Adults and juvenile wards or dependents⁶ of the state who are facing commitment are entitled to protections set forth in the Lanterman-Petris-Short ("LPS") Act.⁷ The legislative intent of the Act in relevant part is:

- (a) To end the inappropriate, indefinite, and involuntary commitment of mentally disordered persons, . . . and to eliminate legal disabilities;
- (b) To provide prompt evaluation and treatment of persons with serious mental disorders . . . ;
- (c) To guarantee and protect public safety;
- (d) To safeguard individual rights through judicial review;
- (e) To provide individualized treatment, supervision, and placement services by a conservatorship program for gravely disabled persons;
.....⁸

6. Minors can be adjudged wards of the juvenile court based on delinquency, or commission of crimes or violation of court orders. *See* CAL. WELF. & INST. CODE §§ 601-02 (West 1984). Minors can be adjudged dependents of the juvenile court if there are findings of abuse and/or neglect. *See* § 300(a)-(j).

7. CAL. WELF. & INST. CODE §§ 5000-5150.

Different procedures and protections apply depending upon the length of the commitment. After an initial commitment of seventy-two hours, which is governed by separate statutes for adults and minors,⁹ a commitment for an additional fourteen days can be sought. The due process protections which apply to adults and children are identical:¹⁰ an automatic certification review proceeding occurs,¹¹ and the certified person is also entitled to petition the court for habeas corpus review.¹² At the certification review, the certified person is entitled to be represented by counsel or an advocate, to present evidence, to question witnesses, and to make reasonable requests for the attendance of facility employees with knowledge of the certification.¹³ The hearing is conducted by a court-appointed commissioner or a referee, or by a certification review hearing officer.¹⁴ At the certification review, in order to detain the certified person, the hearing officer must find that there is probable cause to believe that the person is, as a result of a mental disorder, a danger to others, or to himself or herself, or gravely disabled.¹⁵ Should the certified person request review by habeas corpus, he or she has a right to counsel,¹⁶ and to challenge findings by a preponderance of the evidence.¹⁷

After the 14 day commitment, additional commitments for up to 180 days may be sought.¹⁸ In some cases, if the certified person is thought to be gravely disabled, appointment of a conservator may be sought.¹⁹ In either case, a petition is filed with the court, and a hearing is held.²⁰ The certified person or proposed conservatee is entitled to the right to counsel,²¹ notice and a judicial hearing,²² a jury trial,²³ and a unanimous ver-

8. § 5001.

9. See §§ 5150 (for adults), 5585 (for minors). There must be probable cause in order to effect the commitment of either an adult or a minor. §§ 5150, 5585.50. These statutes are identical with the exception that in the case of minors, authorization for voluntary treatment must be unavailable in order to proceed under this section, and efforts to notify the minor's parent or legal guardian must occur as soon as possible after the commitment. In addition, "gravely disabled minor" is statutorily defined. § 5585.25.

10. See CAL. WELF. & INST. CODE §§ 5585.53, 5250 (West, WESTLAW through 1997 portion of 1997-98 Reg. Sess. and 1st Ex. Sess.).

11. See § 5256.

12. See § 5275.

13. See § 5256.4.

14. See § 5256.1.

15. See § 5256.5.

16. See § 5276.

17. See *In re Azzarella*, 254 Cal. Rptr. 922 (Cal. Ct. App. 1989).

18. See CAL. WELF. & INST. CODE § 5300 (West, WESTLAW through 1997 portion of 1997-98 Reg. Sess. and 1st Ex. Sess.).

19. See § 5350.

20. See §§ 5301, 5303, 5352, 5365.

21. See §§ 5302, 5365.

22. See §§ 5301, 5362.

23. See §§ 5302, 5362.

dict.²⁴ In addition, the standard of proof is proof beyond a reasonable doubt.²⁵

B. *Parham and Roger S*

In contrast to the LPS system governing commitments of adults and juvenile dependents and wards, children facing commitments by their parents have fewer protections. In considering challenges to state hospital commitment decisions by parents involving their children, both the U.S. Supreme Court and the California Supreme Court reached conclusions which balanced the interests of the child, parents, and state. *Parham v. J.R.*²⁶ involved a challenge to Georgia's statute permitting commitments of children under eighteen years of age by their parent or guardian.²⁷ J.R. had been declared a neglected child at the age of three months and had been placed in a series of foster homes.²⁸ When he was seven years old, the state agency which was his guardian committed him to a state hospital.²⁹ A second appellee, J.L., was committed to a state hospital at age six by his parents.³⁰

While recognizing that children have a protectable interest in being free from unnecessary bodily restraint,³¹ the U.S. Supreme Court also found that "[o]ur jurisprudence historically has reflected Western civilization concepts of the family as a unit with broad parental authority over minor children."³² As a result, the Court found that the only due process protection to which children are entitled is a right to an inquiry by a neutral factfinder to determine whether the statutory requirements for admission are satisfied.³³ The statute at issue provided that a minor could be admitted "[i]f found to show evidence of mental illness and to be suitable for treatment."³⁴ The inquiry can be an informal proceeding³⁵ and the factfinder need not be a judicial officer.³⁶ The opinion was silent on the

24. *See* Conservatorship of Roulet, 590 P.2d 1 (Cal. 1979); Conservatorship of Davis, 177 Cal. Rptr. 369 (Cal. Ct. App. 1981).

25. *See* Roulet, 590 P.2d at 4.

26. 442 U.S. 584 (1979).

27. *See id.* at 588.

28. *See id.* at 590.

29. *See id.*

30. *See id.* at 589.

31. *See id.* at 601.

32. *Id.* at 602.

33. *See id.* at 606. *Parham* also decided that the same due process rights apply when the juvenile is a ward of the state. *See id.* But *cf. supra* notes 6-25 and accompanying text (discussing California's treatment of juvenile wards).

34. *Parham*, 442 U.S. at 588 n.3.

35. *See id.* at 607.

36. *See id.*

issue of the right to representation by counsel. With regard to the standard of review, the Court stated that "the questions are essentially medical in character: whether the child is mentally or emotionally ill and whether he can benefit from the treatment that is provided by the state."³⁷

Two years before *Parham*, the California Supreme Court in *In re Roger S.* anticipated the U.S. Supreme Court by finding that minors fourteen years old or older have a liberty interest, but that the interest is not co-extensive with that of adults.³⁸ The case involved a fourteen-year-old boy who was hospitalized at Napa State Hospital by his mother and wanted to be released. However, in an important departure from the later-decided *Parham*, the California Supreme Court recognized that parents' right to exercise authority over their children and the right of the child to independently exercise his or her right to due process may conflict.³⁹ The California Supreme Court went on to provide more protections to minors than the U.S. Supreme Court provided. The due process protections to which California minors fourteen and older are entitled when their parents seek to commit them to public institutions are as follows: a precommitment hearing after notice; an opportunity to appear and present evidence; the right to confront and cross-examine witnesses; a neutral and detached decision-maker; findings by a preponderance of the evidence; a record of the proceedings; and the right to counsel.⁴⁰ However, like *Parham*, there need not be a judicial hearing and the minor is not entitled to a jury trial.⁴¹ The determination to be made during the review process is whether "the minor is mentally ill or disordered, and whether, if the minor is not gravely disabled or dangerous to himself or others as a result of mental illness or disorder, the admission sought is likely to benefit him."⁴² The findings must be supported by a preponderance of the evidence.⁴³

C. *Roger S.* Implementation

Roger S. left it to the California state legislature to implement its mandate:

We shall explain . . . the basis for our conclusion and, as guidance to the Legislature in formulating new statutory procedures to protect . . . minors [whose parents seek to commit them] against possible arbitrary admission to mental hospitals, we shall outline those proce-

37. *Id.* at 609.

38. *In re Roger S.*, 569 P.2d 1286, 1290 (Cal. 1977).

39. *See id.* at 1291-92.

40. *See id.* at 1296.

41. *See id.* at 1297.

42. *Id.* at 1289.

43. *See id.* at 1296.

dures which will afford at least those minimum protections to which they are constitutionally entitled.⁴⁴

However, in the years following the decision, the legislature was unable to agree upon the type of hearing necessary to meet the standards set forth in the case. Eventually, each county faced a decision whether to implement its own *Roger S.* process, or to continue to wait for legislative direction. A survey conducted in 1982 indicated that most of the responding counties had decided not to implement special *Roger S.* hearings.⁴⁵ Instead, a majority of counties decided to use LPS conservatorships as the means to commit minors to state facilities.⁴⁶ However, more than half of these counties allow minors to waive their LPS rights.⁴⁷ Some counties had already created or were in the process of creating a special *Roger S.* hearing to be held before juvenile court judges or commissioners.⁴⁸

From my own recent limited survey of counties, it is difficult to determine whether the policies adopted in the 1980s have been retained.⁴⁹ Of the four counties responding to the survey, only three participated in the earlier survey in 1982.⁵⁰ Of those three, two are using the same or somewhat modified procedures as those adopted in the wake of *Roger S.*⁵¹ The remaining county, Marin, indicated that in 1982 both LPS conser-

44. *Id.* at 1289.

45. See Carol K. Dillon et al., *In re Roger S.: The Impact of a Child's Due Process Victory on the California Mental Health System*, 70 CAL. L. REV. 373, 435-36 and app. B(1) (1982).

46. See *id.* 18 of 30 counties responded that LPS conservatorships were being used.

47. See *id.* 12 of the 18 counties allowed waivers of LPS rights.

48. See *id.* Three counties had *Roger S.* procedures; three others were in the process of implementing them.

49. This survey was a limited follow-up to the survey conducted by Dillon et al., *supra* note 45. We posed similar questions. We also asked about county procedures for the admission of minors to private psychiatric facilities and whether the passage of S.B. 595 had any impact on such admissions. See *infra* notes 59-67.

The survey was faxed to the Patients' Rights Advocate (or director, chief, or coordinator of the particular office) for ten of the largest California counties in July and August of 1997. California Welfare and Institutions Code § 5520 (1984) requires each local mental health director to appoint or contract for the services of one or more patients' rights advocates. Their duties include monitoring mental health facilities for compliance with statutory and regulatory patients' rights provisions. The ten counties were: Alameda, Los Angeles, Marin, Orange, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura. Responses were received from four counties: Los Angeles, Marin, San Bernardino, and Ventura. Follow-up telephone calls were made to these Patients' Rights Advocates to clarify or obtain additional information.

50. San Bernardino County did not participate in the survey conducted by Dillon et al., *supra* note 45, at 435-36 and app. B(1).

51. Los Angeles and Ventura counties participated in both surveys. See Dillon et al., *supra* note 45, at 435-36 and app. B(1); *supra* note 49.

vatorships and *Roger S.* hearings were used to obtain commitments.⁵² Presently, in this county, conservatorships are rarely used, and *Roger S.* hearings are not used at all. This is apparently the result of the fact that currently this county does not consider the state mental hospital as a treatment option for minors.

Roger S. left open the question of what due process rights attach for children younger than fourteen years old.⁵³ In practice, since there are no due process protections in place, parents are able to commit their children under fourteen to state inpatient hospitals as long as a physician consents.⁵⁴ Patients' Rights Advocates responding to the survey⁵⁵ indicated that they are not notified when children under the age of fourteen are hospitalized by their parents in public or private facilities.

D. The Alternative Scheme for Private Hospitals ("S.B. 595")

Neither *Parham*, *Roger S.* nor the LPS Act address commitments of minors to private hospitals. The process available to children, fourteen and older, whose parents seek to have them admitted to private, as opposed to public, facilities came about as a result of a legislative compromise struck in 1989. During the legislative session, two bills concerning private inpatient commitments of minors were introduced. A.B. 2424, authored by assemblymember Richard Polanco, and sponsored by the California Association of Mental Health Patients Rights Advocates ("CAMHPRA"), provided *Roger S.* type protections for minors between the ages of fourteen and eighteen, with the exception of a *post-*, rather than a *pre-*, commitment hearing.⁵⁶ In the same session, Senator Robert Presley introduced S.B. 595, which was sponsored by hospitals and physicians.⁵⁷ It provided for more limited protections of the sort outlined in *Parham*. When the bills went to conference committee, the core provi-

52. See Dillon et al., *supra* note 45, at 435-36 and app. B(1); see also *supra* notes 50-51.

53. *Roger S.*, 569 P.2d at 1289 n.3. ("We have no occasion in the instant case to consider the lawfulness of the [Welfare and Institutions Code] section 6000, subdivision (b) admission procedure as applied to children under 14 years of age.")

54. Judge Stephen M. Lachs has written that "I know of no cases in Los Angeles where there have been requests for judicial intervention concerning the placing of a minor under fourteen years of age in a state mental hospital over his protest." Stephen Lachs, *Placing Minors in California Mental Hospitals*, 4 WHITTIER L. REV. 57, 62 (1982).

The discharge data from the State of California Office of Statewide Health Planning and Development ("OSHPD"), *infra* note 199, indicates that 9621 and 8165 minors under the age of 14 were committed to inpatient psychiatric care in California county and private facilities in 1990 and 1995, respectively.

55. See *supra* note 49 for explanation of Patients' Rights Advocate system and description of survey methodology.

56. See Comm. Rep. A.B. 1276 (Cal. Apr. 23, 1991).

57. See *id.*

sions of S.B. 595 were preserved and became effective on January 1, 1990.⁵⁸

S.B. 595 was codified in the Welfare and Institutions Code.⁵⁹ The due process requirements only apply to private mental health facilities where the costs of treatment are paid or reimbursed by a private insurer or private health service plan.⁶⁰ The review is held *after* the child has been admitted,⁶¹ within five days of a request.⁶² If there is no request, a review does not take place.⁶³ The independent review is conducted by a psychiatrist.⁶⁴ The standard of review also differs from the *Roger S.* standard. The commitment decision can be affirmed if there is a finding that the treatment is "reasonably likely to be beneficial."⁶⁵ In making the determination, the reviewing psychiatrist conducts a private interview with the minor at which an advocate is permitted to be present.⁶⁶ Finally, the statute specifically provides that there is no right to representation by counsel during the review process.⁶⁷

Thus, in California, the extent of minors' due process rights depends on the following: the age of the minor, who is trying to commit the minor, whether the commitment sought is to a public or private facility, and who is paying for the treatment.⁶⁸

II. The Unique Impact of Existing Law and Procedures on Gay Youth

Dear Desperate, continued:

Children in your situation often feel confused and frightened, especially today. Some parents and segments of society feel very strongly that being homosexual, bisexual or transgender is morally wrong or abnormal. Others think that there's nothing wrong with being homosexual, bisexual or transgender, and that it's societal intolerance that causes many gay youth to be unhappy. In either case, parents have a

58. See Comm. Rep. A.B. 1276 (Cal. July 17, 1991).

59. See CAL. WELF. & INST. CODE §§ 6002.10-.40 (West, WESTLAW through 1997 portion of 1997-98 Reg. Sess. and 1st Ex. Sess.).

60. See § 6002.40(b). This means that commitments by parents where treatments are paid for directly by the parent are not subject to *any* procedural protections.

61. See § 6002.20.

62. See § 6002.30(d).

63. See § 6002.15(b) (requiring minors to be advised of their right to an independent clinical review).

64. See § 6002.25.

65. § 6002.30(c).

66. See § 6002.30(a), (e).

67. See § 6002.30(i).

68. Ironically, this is an arena in which poor children have substantially greater protections than rich children.

great deal of power to control your life. You should also know that the official position of the American Psychiatric Association is that homosexuality is not a mental disorder.

Assuming for the moment that your parents decide to try to commit you to a mental hospital, you have the right to challenge this decision. Only you can decide whether to exercise this right or not. You might think about whether you think the treatment you'll receive will be helpful to you and whether the alternatives are any better—will you be sent back home, or is there another placement? How do you feel about opposing your parents' wishes? What is the motivation behind your parents' decision? How do they feel about homosexuality? Are they really acting with your best interests at heart? How do you feel about the doctors you've been seeing, if any? What does their attitude toward homosexuality seem to be? Finally, how do you feel about homosexuality? Do you want help getting used to your homosexuality, or do you want help dealing with your confusion about your sexual orientation?

In assessing the effectiveness and appropriateness of the commitment process for gay children, it is important to understand the social climate surrounding sexual minorities, as well as the law's attitude toward children in general.

A. Changing Social and Legal Context for Gays

Today, the topic of homosexuality is out of the closet. The rightful place of those who are gay, lesbian, bisexual, and transgender is openly discussed in many different contexts. Should gays be allowed to serve in the military,⁶⁹ should they be protected from workplace discrimination,⁷⁰ should they be allowed to marry,⁷¹ are they fit as parents,⁷² or do they represent an abomination?⁷³ These are all issues that are being widely debated among policymakers, in the courts, in the media, and among many members of society in general.

But open debate does not bring instant acceptance or tolerance. A recent poll in California found that a majority of those polled favor

69. For example, negative reactions came from both ends of the political spectrum in response to President Clinton's announcement of the "Don't Ask, Don't Tell" policy applying to gays in the military.

70. See, e.g., *infra* notes 85-86.

71. See, e.g., *infra* notes 75 and 81-83.

72. For example, states vary as to whether adoptions by openly gay persons are permitted. See Nancy D. Polikoff, *Resisting "Don't Ask, Don't Tell" in the Licensing of Lesbian and Gay Foster Parents: Why Openness Will Benefit Lesbian and Gay Youth*, 48 HASTINGS L.J. 1183 (1997).

73. For example, Promise Keepers founder Bill McCartney has called homosexuality an "abomination of Almighty God." Beth Myers, *NOW Promises "No Surrender" to Right-Wing Promise Keepers*, NATIONAL TIMES, Oct. 1997, at 1.

granting legal recognition to gay domestic partners in areas such as hospital visitation rights, medical powers of attorney and conservatorships, and granting status to domestic partners to receive benefits such as pensions, health and dental care coverage, family leave, and death benefits.⁷⁴ The same poll found, however, that a majority opposed having a law permitting gays to marry members of their own sex and having regular marriage laws applied to them.⁷⁵ The results of this poll seem to reflect a growing tolerance, but far from total acceptance, of the legitimacy of gay relationships.

Ironically, disapproval and intolerance of homosexuality is arguably increasing at the same time acceptance is growing. Klanwatch, a project of the Southern Poverty Law Center, publishes *Intelligence Report*. It compiles reports of incidents of violence, including those directed toward gay, lesbian, bisexual, and transgender people. A collation of reports from the last several issues of *Intelligence Report* shows that approximately 9% of the reports indicated that sexual orientation or perceived sexual orientation of the victim was a motivating factor in the incident.⁷⁶ Incidents of hate crimes, generally, are on the increase.⁷⁷

Societal ambivalence about homosexuality is reflected in the legal sphere as well. In 1960, all fifty states and the District of Columbia outlawed sodomy.⁷⁸ Since 1960, thirty states have decriminalized it.⁷⁹ Some communities have voted to offer domestic partner benefits to their resi-

74. 67% of those polled favored granting legal recognition to domestic partners in areas of family rights such as hospital visitation rights, medical powers of attorney, and conservatorships. 59% favored granting financial dependence status to domestic partners to receive benefits such as pensions, health and dental care coverage, and family leave and death benefits. See Kenneth J. Garcia, *Californians Accepting Gay Rights*, S.F. CHRON., Mar. 3, 1997, at A1 (reporting on the results of the Field Poll, conducted between Feb. 11 and 17, 1997).

75. 56% of those polled disapproved of a law permitting homosexuals to marry members of their own sex with regular marriage laws applied to them. See *id.*

76. Reports mentioning sexual orientation of the victim were tallied from the reports published in the Winter, Spring, and Summer 1997 issues of *Intelligence Report*. Of 710 total incidents, 64 indicated that sexual orientation was a motivating factor. See *Bias Incidents*, INTELLIGENCE REPORT, Winter 1997, at 23, 23-34; *For the Record*, INTELLIGENCE REPORT, Winter 1997, at 35, 35-39; *For the Record*, INTELLIGENCE REPORT, Summer 1997, at 19, 19-27; *For the Record*, INTELLIGENCE REPORT, Spring 1997, at 31, 31-35. INTELLIGENCE REPORT draws its summaries from media and law enforcement reports. They state that "statistics on hate crimes are unreliable, because many bias-motivated crimes are not reported to law enforcement, and law enforcement monitoring of hate crimes varies from state to state." *Bias Incidents*, INTELLIGENCE REPORT, Winter 1997, at 23, 23.

77. *Clinton Declares 'All-Out Assault on Hate Crimes'*, WASH. POST, June 8, 1997, at A6 (citing FBI statistics showing a 42% rise in reported hate crimes from 1991 to 1995).

78. See ROBERT WINTEMUTE, *SEXUAL ORIENTATION AND HUMAN RIGHTS* 20 (1995). Sodomy laws make it a crime to engage in all oral or anal intercourse, between men, between women, or between a man and a woman.

79. See National Gay and Lesbian Task Force, *Montana Supreme Court Strikes Down State's Sodomy Law* (visited Feb. 3, 1997) <<http://www.ngltf.org/press/mont-sod.html>>.

dents.⁸⁰ On the other hand, last year, Congress passed, and President Clinton signed into law, the Defense of Marriage Act.⁸¹ This law, which explicitly defines marriage as between a woman and a man,⁸² was passed in reaction to the Hawaii marriage case, *Baehr v. Miike*.⁸³ *Baehr* has in turn spawned passage in Hawaii of a very broad state-wide domestic partner benefits bill which became effective on July 1, 1997.⁸⁴ This session, Congress will reconsider the Employment Non-Discrimination Act,⁸⁵ which narrowly failed to pass the Senate last session.⁸⁶

The U.S. Supreme Court has not been immune from society's ambivalence toward gays. In 1986 *Bowers v. Hardwick*⁸⁷ held that sodomy statutes, such as the one challenged by a gay man who was prosecuted under Georgia's statute, are constitutional, because they do not violate the right to privacy.⁸⁸ Ten years later, in 1996, the Court in *Romer v.*

80. The National Gay Lesbian Task Force posted "A Sampling of Domestic Partner Benefits" dated July 15, 1996, at its website. It lists approximately 158 private companies, 44 public sector entities, 69 universities and colleges, 27 non-profit organizations, and 24 labor organizations as offering some form of domestic partner benefits. The listing does not purport to be complete. National Gay Lesbian Task Force, *A Sampling of Domestic Partner Benefits* (last modified July 15, 1996) <<http://www.ngltf.org/pubs/dpbene.html>> .

81. Defense of Marriage Act of 1996, Public Law 104-199, 110 Stat. 2419 (codified at 1 U.S.C.A. § 1, 28 U.S.C.A. § 1738C (West 1997 & Supp. 1998) .

82. Section 3 of the Act adds a definition of "marriage" and "spouse" to Chapter 1, Title 1 of the United States Code. 1 U.S.C.A. § 7 (West 1997). This definition provides that "[i]n determining the meaning of any Act of Congress, or of any ruling, regulation, or interpretation of the various administrative bureaus and agencies of the United States, the word 'marriage' means only a legal union between one man and one woman as husband and wife, and the word 'spouse' refers only to a person of the opposite sex who is a husband or a wife." *Id.*

83. *Baehr v. Lewin*, 852 P.2d 44 (Haw. 1993). Plaintiffs applied for and were denied marriage licenses because Hawaii Revised Statutes § 572-1 (1985) (amended 1997) (governing issuance of marriage licenses) was interpreted to apply to opposite sex couples. *See id.* at 48-50. Plaintiffs filed an action seeking declarative relief as to the construction and application of Hawaii Revised Statutes § 572-1. *See id.* The Hawaii Supreme Court remanded the case to the circuit court for further proceedings. *See id.* at 68. "On remand, in accordance with the "strict scrutiny" standard, the burden will rest on [Defendant] to overcome the presumption that HRS § 572-1 is unconstitutional by demonstrating that it furthers compelling state interests and is narrowly drawn to avoid unnecessary abridgments of constitutional rights." *Id.*

84. HAW. REV. STAT. §§ 572C-1 to -7 (1997). The so-called "Reciprocal Beneficiaries" or "Reciprocal Benefits" bill purports to extend benefits to couples who are precluded by law from marrying. *Id.* Among the benefits covered are rights to inheritance, retirement beneficiary benefits, and health-related benefits. *Id.*

85. The House version, H.R. 1858, was introduced by Congressman Christopher Shays (R-CT), and 152 co-sponsors. H.R. 1858, 105th Cong. (1997). The Senate version, S. 869 was introduced by Senator James Jeffords (R-VT), and 33 co-sponsors. S. 869, 105th Cong. (1997).

86. S. 2056, 104th Cong. (1996) (failed to pass the Senate by a vote of 50 to 49 on Sept. 30, 1996).

87. 478 U.S. 186 (1986).

88. *See id.* at 189.

*Evans*⁸⁹ found that a state constitutional amendment precluding any governmental action designed to protect "homosexual, lesbian or bisexual orientation" was violative of the Fourteenth Amendment's equal protection clause.⁹⁰ In its six to three majority opinion, the Court found Colorado's constitutional amendment "classifies homosexuals not to further a proper legislative end but to make them unequal to everyone else."⁹¹ In his dissent, Justice Scalia described the majority opinion as contradicting *Bowers* and "plac[ing] the prestige of this institution behind the proposition that opposition to homosexuality is as reprehensible as racial or religious bias."⁹²

Children today are often victims of the high visibility of, and widely divergent attitudes toward, gay issues. While there are indications that greater societal tolerance and visibility of gay issues has resulted in children "coming out" at an earlier age, these children may be subjected to open hostility; hatred in arenas which ought to provide a safe and secure environment; and intolerance, often within their own families, schools, and communities.⁹³ In particular, schools are notoriously ignorant of, and/or hostile toward, their gay students, and in some cases school officials permit harassment and/or violence toward them.⁹⁴

89. 116 S. Ct. 1620 (1996)

90. *See id.* at 1624.

91. *Id.* at 1629.

92. *Id.* (Scalia, J., dissenting).

93. *See* Anthony R. D'Augelli & Scott L. Hershberger, *Lesbian, Gay and Bisexual Youth in Community Settings: Personal Challenges and Mental Health Problems*, 21 AM. J. COMMUNITY PSYCHOLOGY 421, 422 (1993).

94. *See, e.g.,* *Nabozny v. Podlesny*, 92 F.3d 446 (7th Cir. 1996) (describing how Jamie Nabozny was continually harassed and physically abused by fellow students because of his homosexuality throughout middle and high school). There was evidence to suggest that some school administrators did not take Nabozny's predicament seriously. *See id.* at 449.

The Safe Schools Project is a five-year study being conducted state-wide in Washington State. The third annual report of the study published in Fall 1996 reports on the results of a survey of 8400 Seattle high school students. Students who described themselves as gay, lesbian or bisexual were significantly more likely than their heterosexual peers to report the following: having been the target of anti-gay harassment or violence at school or on the way to or from school; having been threatened or injured by someone with a weapon at school in the past year; having been injured in a fight in the last year severely enough to have been treated by a doctor or a nurse; feeling unsafe or afraid at school some, most or all of the time; and, having missed at least one day of school in the past month because they felt unsafe. *See Safe Schools Anti-Violence Documentation Project, Third Annual Report, Executive Summary: Fall 1996* (visited Feb. 19, 1997) <http://members.tripod.com/~claytoly/ssp_execsum>.

B. Changing and Conflicting Treatment of Children Under the Law, Generally

Just as society and its laws regard sexual minorities with ambivalence, society and its laws also regard children with mixed feelings. In certain situations, children, beginning at age fourteen, can be treated as adults. Emancipation statutes are available to minors as young as fourteen years old. If a certain showing is made, a minor can be emancipated from the control of his or her parents, and is thereafter treated as an adult.⁹⁵ Children as young as fourteen years old who are accused of committing some offenses may be tried as adults.⁹⁶

In other contexts, minors are subject to constraints imposed by the state or their parents which differ from those which can be imposed upon adults. Minors are restricted in their ability to obtain driver's licenses,⁹⁷ to enter into binding contracts,⁹⁸ to purchase alcoholic beverages⁹⁹ or tobacco products,¹⁰⁰ and must attend school.¹⁰¹ Children are also subject to curfew laws,¹⁰² and other status offenses¹⁰³ for which adults cannot be punished.

The factors affecting how children will be treated in any given situation vary greatly. Children's rights as autonomous persons are greatly tempered by a number of competing interests: among them the right of parents to raise their children as they see fit, state interests such as ensuring that children have minimum levels of education, and a recognition that children are still developing judgment and decision-making capabilities. However, it is clear that children's capacities to make good decisions for themselves are not the overriding concern in crafting laws or defining circumstances in which children are deemed to be able to act on their own behalf or are to be treated as adults.

A recent California Supreme Court decision illustrates this point, and has broader implications for the commitment issue considered here. In *American Academy of Pediatrics v. Lungren*,¹⁰⁴ the court, in a four to

95. CAL. FAM. CODE §§ 7000-7143 (West 1994).

96. CAL. WELF. & INST. CODE §§ 707-707.4 (West 1984).

97. CAL. VEH. CODE §§ 17700, 17701 (West 1971).

98. CAL. CIV. CODE § 1556 (West 1982).

99. CAL. BUS. & PROF. CODE § 25658 (West 1997).

100. CAL. PENAL CODE § 308(b) (West 1988).

101. CAL. EDUC. CODE § 49100 (West 1993).

102. See *In re Nancy C.*, 105 Cal. Rptr. 113 (Cal. Ct. App. 1972).

103. For example, unmarried minors cannot legally consent to sexual intercourse. See CAL. PENAL CODE § 261.5 (West 1988). This is California's statutory rape law. Under Welfare & Institutions Code § 601(b) (1984), a minor can be adjudged a ward of the court if the minor has four or more trancies within one school year, or for persistent or habitual refusal to obey the reasonable and proper orders or directions of school authorities.

104. 940 P.2d 797 (Cal. 1997).

three plurality decision, held that California's parental notification or judicial bypass petition requirement for all unemancipated minors to obtain abortions was unconstitutional.¹⁰⁵ The plurality opinion found that the State had failed to establish that its compelling interest in protecting both the health of the minor and the parent-child relationship was furthered by a law requiring parental notification or judicial authorization prior to a minor obtaining an abortion.¹⁰⁶ In support of its decision, the court considered the numerous, analogous California statutory provisions authorizing a minor, without parental consent, to make medical and other significant decisions with regard to her own and her child's health and future.¹⁰⁷ In addition, the court cited overwhelming evidence introduced at trial that the parental notice or judicial bypass process would injure the interests of the minor's health and the parent-child relationship.¹⁰⁸ Most relevantly, the court held that an unemancipated minor's privacy right when making a decision to have an abortion is similar to an adult's.¹⁰⁹ The court went on to state that

because the decision whether to continue or terminate her pregnancy has such a substantial effect on a pregnant minor's control over her personal bodily integrity, has such serious long-term consequences in determining her life choices, is so central to the preservation of her ability to define and adhere to her ultimate values regarding the meaning of human existence and life, and (unlike many other choices) is a decision that cannot be postponed until adulthood, we conclude that a minor who is pregnant has a protected privacy interest under the California Constitution in making the decision whether to continue or to terminate her own pregnancy — and that this interest is intruded upon by the provisions of [the parental consent or judicial bypass statute].¹¹⁰

For a bare majority of the current California Supreme Court, the balance among the interests of children, parents, and the state favored the privacy right of children. The court was particularly persuaded by the nature of the decision being weighed, that is, whether to terminate a pregnancy. The court also deferred to medical personnel to make the individual determination of the minor's capacity to make an informed deci-

105. *See id.* at 800.

106. *See id.* at 828.

107. *See id.* at 815. The court noted that the statute being challenged, California Family Code § 6925 (West 1994), permitted unmarried pregnant minors to obtain medical care related to pregnancy without parental consent. *See id.* at 815. The court also cited statutes which permit minors, 12 and older, without parental consent, to seek out treatment for infectious diseases, including sexually transmitted diseases (§ 6926), treatment for rape (§ 6927), treatment for drug or alcohol abuse (§ 6929) and mental health treatment on an outpatient basis (§ 6924). *See id.* at 827, 830. California Family Code § 6928 allows a minor of any age and without parental consent, to seek medical care for sexual assault. *See id.* at 827.

108. *See id.* at 802.

109. *See id.* at 816 & n.21.

110. *See id.* at 816.

sion. The separate dissents by Justices Mosk, Baxter, and Brown argued that the balancing should have favored the interests of parents or the state over those of the minor. Thus, while there was much testimony at trial as to the capacity of minors to make competent decisions on their own, the plurality seemed less persuaded by such testimony than by the profound nature of the decision and rights at stake. Similarly, the dissenting justices seemed unpersuaded that the capacity of minors ought to be a consideration at all, given the other, "superior" interests at stake.

Of particular note is Justice Mosk's heavy reliance upon the reasoning in *Roger S.* in his dissent. After summarizing the principles which could be derived from *Roger S.*, he applied them to the abortion context. Justice Mosk argued that the minor's right to privacy, much like a minor's liberty right, is more limited than an adult's, and is subject to interference by the state.¹¹¹ However, he cautioned that, as with the commitment decision, the state's interference with the minor's exercise of the right to decide whether to obtain an abortion may be detrimental to the minor.¹¹² As such, procedures which are imposed must protect minors from arbitrary or drastic interference with their rights.¹¹³ As in *Roger S.* he concluded that since a minor's rights are subject to greater restrictions than adults that in this case, parental consent or notice, or judicial authorization, while not appropriate for adult women, are appropriate restrictions for minors.¹¹⁴

Justice Mosk implied that *American Academy of Pediatrics* set the court on a collision course with its decision in *Roger S.* Indeed, *American Academy of Pediatrics* could well pave the way for increasing the due process protections to which minors are entitled. The liberty right implicated in the commitment decision is similar to the privacy right implicated in the decision to obtain an abortion. As with the abortion decision, commitment has a "substantial effect on a . . . minor's control over her personal bodily integrity, has . . . serious long-term consequences . . . and is . . . central to the preservation of her ability to define and adhere to her ultimate values regarding the meaning of human existence and life."¹¹⁵ These arguments support revisiting *Roger S.* to expand the scope of *American Academy of Pediatrics* to protect gay children from unwarranted commitment decisions.

111. See *id.* at 854 (Mosk, J., dissenting).

112. See *id.* at 856 (Mosk, J., dissenting).

113. See *id.* (Mosk, J., dissenting).

114. See *id.* at 857 (Mosk, J., dissenting).

115. *Id.* at 816.

C. Critique of *Parham*, *Roger S.*, and S. B. 595 with Regard to Gay Youth

In reaching its decisions in *Parham* and *Roger S.*, the U.S. and California Supreme Courts relied upon a series of assumptions which have been heavily criticized by academics.¹¹⁶ Several key criticisms will be revisited briefly, and will then be scrutinized with regard to gay youth.

(1) *Assumption that Commitment Decision is Purely a Medical Decision Which Medical Experts Are in the Best Position to Make*

a. Lack of admissions standards for minors

Parham and *Roger S.* acknowledged the unreliability of mental health diagnoses of, and prognoses for, children. "[W]e note again the uncertainties in psychiatric diagnosis and the divergence of expert views which render the possibility of mistake significantly greater than in diagnosis of physical illness."¹¹⁷ "[W]e acknowledge the fallibility of medical and psychiatric diagnosis."¹¹⁸

Nevertheless, in *Parham*, commitment decisions were held to be medical decisions which are best left to experts in the field. "[W]e do not accept the notion that the shortcomings of specialists can always be avoided by shifting the decision from a trained specialist using the traditional tools of medical science to an untrained judge or administrative hearing officer after a judicial-type hearing."¹¹⁹ *Roger S.* diverged from this view, expressing concern about erroneous diagnoses and finding that the screening procedure employed by the hospitals was insufficient to meet due process requirements.¹²⁰

116. See John H. Garvey, *Children and the Idea of Liberty: A Comment on the Civil Commitment Cases*, 68 KY. L.J. 809 (1979-80); Allen Edward Shoenberger, "Voluntary" Commitment of Mentally Ill or Retarded Children: Child Abuse by the Supreme Court, 7 U. DAYTON L. REV. 1 (1981); Sidney S. Hollar, *The Never-Never Land of Mental Health Law: A Review of the Legal Rights of Youth Committed by Their Parents to Psychiatric Facilities in California*, 4 BERKELEY WOMEN'S L.J. 300 (1988-89); Katharine A. Butler, *A Chance to be Heard: An Application of Bellotti v. Baird to the Civil Commitment of Minors*, 32 HASTINGS L. J. 1285 (1981); Malissa D. McKeith, *Children's Inpatient Mental Health Treatment: Extending Due Process to All Commitment Procedures*, 17 U.S.F. L. REV. 797 (1983); Kelli Schmidt, "Who are you to say what my best interest is?" *Minors' Due Process Rights when Admitted by Parents for Inpatient Mental Health Treatment*, 71 WASH. L. REV. 1187 (1996). Much of this work was influenced by James W. Ellis, whose seminal article was cited in the *Parham* and *Roger S.* decisions. See James W. Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 CAL. L. REV. 840 (1974).

117. *In Re Roger S.*, 569 P.2d 1286, 1290 (Cal. 1977) (citation omitted).

118. *Parham v. J.R.*, 442 U.S. 584, 609 (citation omitted).

119. *Id.*

120. *Roger S.*, 569 P.2d at 1295-96.

The concern expressed in *Roger S.* is well founded. Critics have pointed out that, unlike the situation for adults, there are no widely accepted standards for adolescent admissions for inpatient care.¹²¹ Thus, inpatient admission decisions can be made in inconsistent and unpredictable ways, depending on the facility and the medical personnel. Lois Weithorn's article describes one set of admission criteria:

The National Association of Private Psychiatric Hospitals ("NAPPH") . . . publishes criteria that could be used to justify the hospitalization of most troublesome, and many not-so-troublesome, juveniles. Not only do these criteria cite "sexual promiscuity" as an example of "self-defeating" and/or "self-destructive" behavior necessitating "immediate acute-care hospitalization [as] the only reasonable intervention," but they fail to define what type of sexual activity constitutes "promiscuity." Such a standard allows anyone using the guidelines to apply personal moral standards in making admission decisions. No link between the sexual activity and a basic mental disturbance must be demonstrated prior to admission; the link apparently is presumed. The NAPPH criteria mention as another justification for hospitalization "inability to function" in one of the following areas: family life, vocational pursuits, and "choice of community resources." The commentary accompanying the criteria implies that teenagers who prefer certain nonfavored social activities (such as listening to punk rock music) over attending scout or church youth group meetings may be making a sufficiently poor "choice of community resources" to justify his hospitalization.¹²²

In failing to acknowledge the lack of standards for adolescent inpatient admissions, both *Parham* and *Roger S.* overlooked the even greater potential for erroneous admissions of adolescents than for adults. The lack of standards suggests the need for stronger, not weaker, oversight protections.

b. Conflict within medical community over homosexuality

Most important for gay children is the controversy within the medical profession about the nature of sexual orientation. This is illustrated by reviewing some of the changes to the *Diagnostic and Statistical Manual of Mental Disorders*¹²³ ("DSM") over the last twenty-five years. In 1973, the Board of Trustees of the American Psychiatric Association,

121. See Lois L. Weithorn, *Mental Hospitalization of Troublesome Youth: An Analysis of Skyrocketing Admission Rates*, 40 STAN. L. REV. 773, 785 (1988).

122. *Id.* at 780 (citations omitted).

123. The Diagnostic and Statistical Manual of Mental Disorders is described as "widely accepted in the United States as the common language of mental health clinicians and researchers for communicating about [mental] disorders." AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS [hereinafter DSM] xviii (3d ed. rev. 1987) [hereinafter DSM-III-R].

which publishes the DSM, voted to eliminate homosexuality per se as a mental disorder and to substitute a new category, Sexual Orientation Disturbance. The removal of homosexuality per se in the third edition of the DSM ("DSM-III") was supported by the following rationale:

The crucial issue in determining whether or not homosexuality per se should be regarded as a mental disorder is not the etiology of the condition, but its consequences and the definition of mental disorder. A significant portion of homosexuals are apparently satisfied with their sexual orientation, show no significant signs of manifest psychopathology (unless homosexuality, by itself, is considered psychopathology), and are able to function socially and occupationally with no impairment. If one uses the criteria of *distress* or *disability*, homosexuality per se is not a mental disorder. If one uses the criterion of *inherent disadvantage*, it is not at all clear that homosexuality is a disadvantage in all cultures or subcultures.¹²⁴

The new category of Sexual Orientation Disturbance applied to those homosexuals who are "disturbed by, in conflict with, or wish to change their sexual orientation."¹²⁵

In 1980, the third edition of the DSM ("DSM-III") was published. The DSM-III continued the 1973 elimination of homosexuality but changed the category of Sexual Orientation Disturbance to "Ego-dystonic homosexuality."¹²⁶ The category of "Gender identity disorder of childhood" was also added to the DSM-III.¹²⁷ The DSM-III did not give any explanation for this second addition.¹²⁸

124. DSM, app. C at 380 (3d ed.1980) [hereinafter DSM-III].

125. *Id.*

126. *Id.* ("The change in terminology was made to make it clear that the category is limited to individuals with a homosexual arousal pattern.")

127. *See id.* at 264.

The essential features are a persistent feeling of discomfort and inappropriateness in a child about his or her anatomic sex and the desire to be, or the insistence that he or she is, of the other sex

Girls with this disorder regularly have male peer groups, an avid interest in sports and rough-and-tumble play, and a lack of interest in playing with dolls or playing "house" (unless playing the father or another male role). . . .

Boys with this disorder invariably are preoccupied with female stereotypical activities. They may have a preference for dressing in girls' or women's clothes Dolls are often the favorite toy Rough-and-tumble play or sports are regularly avoided.

Id.

128. *See id.*, app. C at 380 (comparing the listings appearing in the DSM-II and DSM-III). In addition, it includes comments that attempt to explain the reasons for major changes to the DSM-II classification, terminology, or definitions of the categories. *See id.* No explanation is provided for the addition of gender identity disorder of childhood. *See id.* The appendix cites Richard Green's work entitled *SEXUAL IDENTITY CONFLICT IN CHILDREN AND ADULTS* (1975). *See id.*

In 1987, the DSM-III was revised ("DSM-III-R") and eliminated ego-dystonic homosexuality as a disorder.

This category has been eliminated for several reasons. It suggested to some that homosexuality itself was considered a disorder. In the United States almost all people who are homosexual first go through a phase in which their homosexuality is ego-dystonic. Furthermore, the diagnosis of Ego-dystonic Homosexuality has rarely been used clinically and there have been only a few articles in the scientific literature that use the concept."¹²⁹

In addition, the DSM-III-R re-classified gender identity disorders as falling within a subclass of "Disorders Usually First Evident in Infancy, Childhood, or Adolescence." This was justified because the symptoms of Gender Identity Disorder ("GID") almost always begin in childhood.¹³⁰

Finally, the fourth and latest edition of the DSM, ("DSM-IV"), published in 1994, eliminated transsexualism¹³¹ as a separate disorder, and subsumed it within GID.¹³² In addition, the new, combined category was moved from the section called "Disorders Usually First Evident in Infancy, Childhood, or Adolescence" to the category called "Sexual and Gender Identity Disorders." These changes followed a reappraisal of the diagnostic criteria prescribing who should have sex reassignment surgery and in particular, the findings that the discrete categories of "transsexualism" and "gender identity disorder of adolescence or adulthood, non-transsexual type" in the DSM-III-R were no longer justified.¹³³

These changes in the DSM over the last twenty-four years are reflective of the underlying controversy within the medical community

129. See DSM-III-R, app. D at 426.

130. See *id.* at 424.

131. In the DSM-III, the diagnostic criteria for transsexualism were: "[a] [s]ense of discomfort and inappropriateness about one's anatomic sex[; a] [w]ish to be rid of one's own genitals and to live as a member of the other sex[; and that] [t]he disturbance has been continuous (not limited to periods of stress) for at least two years." DSM-III at 263.

132. 3 DSM SOURCEBOOK 318-19 (4th ed. 1997) [hereinafter DSM-IV].

133. The DSM-III-R categories of "transsexualism" and "gender identity disorder of adolescence or adulthood, nontranssexual type" are

similar except that transsexualism appears to describe gender-dysphoric individuals who have decided on surgical sex reassignment as the solution to their inner distress. The desire to uncouple the clinical diagnosis of gender dysphoria from criteria for approving patients for sex reassignment surgery was one factor in the subcommittee's recommendation that these categories be merged under the heading of gender identity disorder. It is also the perception of many clinicians that there are no distinct boundaries between patients with gender dysphoria who request sex reassignment surgery and those whose cross-gender wishes are of lesser intensity or constancy. This viewpoint, which reflects clinical experience over a number of years, has led to the belief that there is no longer a justification for maintaining discrete categories within the broad category of gender identity disorder.

DSM-IV at 318 (citations omitted).

about homosexuality and GID. Some mental health professionals believe that GID is a precursor to homosexuality or transsexualism, and disagree with the elimination of homosexuality from the DSM. They assert that if GID in children is successfully treated, then homosexuality and transsexualism can be prevented.¹³⁴ One of the principal proponents of this position is George A. Rekers, Ph.D., a Professor of Neuropsychiatry and Behavioral Science, Research Director for Child and Adolescent Psychiatry, and Chairman of Faculty in Psychology at the University of South Carolina School of Medicine in Columbia, South Carolina. Dr. Rekers has written numerous articles and book chapters about gender identity and development of sexuality in children.¹³⁵ He is the editor of a 1995 book entitled *Handbook of Child and Adolescent Sexual Problems*.¹³⁶ In justifying intervention in cases of what he terms "Gender Role Behavior Disturbance" and "Cross Gender Identification Disturbance" to prevent transsexualism and homosexuality, Dr. Rekers proffers three additional reasons: "the psychological maladjustment of gender disturbed children;" "to prevent the serious emotional, social, and economic maladjustments secondary to severe adulthood sexual problems;" and, "to cooperate with appropriate parental concern over gender deviance."¹³⁷

134. "There are numerous interrelated reasons for intervening in the life of a boy diagnosed with a gender disturbance . . . [One reason] is to prevent severe sexual problems of adulthood such as transsexualism and homosexuality that are highly resistant to treatment in later phases of development." George A. Rekers, *Gender Identity Disorder*, J. HUM. SEXUALITY (visited Mar. 20, 1998) <<http://www.leaderv.com/jhs/rekers.html>>. "We know that obligatory homosexuals are caught up in unconscious adaptations to early childhood abuse and neglect and that, with insight into their earliest beginnings, they can change." Charles W. Socarides, *How America Went Gay*, J. HUM. SEXUALITY (visited Mar. 20, 1998) <<http://www.leaderv.com/jhs/socarides.html>>. "Two short term goals have been discussed in the literature: the reduction or elimination of social ostracism and conflict and the alleviation of underlying or associated psychopathology. Longer term goals have focused on the prevention of transsexualism and/or homosexuality." Susan J. Bradley & Kenneth J. Zucker, *Gender Identity Disorder and Psychosexual Problems in Children and Adolescents*, 35 CAN. J. PSYCHIATRY 477 (1990).

135. See, e.g., George A. Rekers, *Assessment and Treatment of Childhood Gender Problems*, in 1 ADVANCES IN CLINICAL CHILD PSYCHOLOGY 267 (B. B. Lahey & A. E. Kazdin eds., 1977); George A. Rekers, *Sexual Problems: Behavior Modification*, in HANDBOOK OF TREATMENT OF MENTAL DISORDERS IN CHILDHOOD AND ADOLESCENCE 268 (B. B. Wolman ed., 1978); George A. Rekers, *Psychosexual and Gender Problems*, in BEHAVIORAL ASSESSMENT OF CHILDHOOD DISORDERS 483 (E. J. Mash & L. G. Terdal eds., 1981); George A. Rekers, *Gender Identity Problems*, in HANDBOOK OF CLINICAL BEHAVIOR THERAPY WITH CHILDREN 658 (Philip H. Borstein & Alan E. Kazdin eds., 1985); George A. Rekers, *Psychosexual Assessment of Gender Identity Disorders*, in 4 ADVANCES IN BEHAVIORAL ASSESSMENT OF CHILDREN AND FAMILIES 33 (R. J. Prinz ed., 1988).

136. HANDBOOK OF CHILD AND ADOLESCENT SEXUAL PROBLEMS (George A. Rekers ed., 1995).

137. Rekers, *supra* note 134.

In terms of treatment options for children with GID, many different options are reported in the literature.¹³⁸ For example, Dr. Rekers has written about use of behavior therapy, which focuses on techniques to modify specific sex-typed behaviors, such as cross-dressing and exclusive play with opposite-sex toys.¹³⁹

Dr. Rekers' views represent a minority among health professionals.¹⁴⁰ In the 1995 edition of *Treatments of Psychiatric Disorders* the chapter entitled "Gender Identity Disorder in Children" begins: "Both the diagnosis and the treatment of gender identity disorder in children remain controversial. Not only is there dispute over what constitutes each, but debate continues over whether either is justified."¹⁴¹ This chapter is written by Dr. Richard Green, who has both a law degree and a medical degree. He has been doing work in the area of GID in children since the 1960s.¹⁴² He was one of several researchers who conducted research on GID at UCLA in the mid-70s.¹⁴³ His chapter on GID in children closes with this statement:

From the foregoing it should be apparent that goals of intervention in gender identity disorder families are limited. There is no convincing data that anything the therapist does can modify the direction of sexual orientation (typically the parents' primary concern). However, intervention may serve a positive purpose. The pediatric culture remains sexist. Markedly gender role atypical children are teased and rejected. The children are unhappy being who they are and are unhappy socially. Their relationships with parents, notably parents of the same gender, are strained. Intervening to modify these sources of discontent is a

138. "Treatment of children with gender identity disorder has been approached from diverse conceptual orientations, including behavior therapy, psychotherapy, parent counseling, family therapy, group therapy and eclectic combinations." Kenneth Zucker & Richard Green, *Psychosexual Disorders in Children and Adolescents*, 33 J. CHILD PSYCHOL. & PSYCHIATRY 107, 137 (1992).

139. See George A. Rekers, et al., *Long-Term Effects of Treatment for Gender Identity Disorder of Childhood*, 3 J. PSYCHIATRY & HUM. SEXUALITY 121, 124-25 (1990). Dr. Rekers is a reported proponent of aversion therapy, in which "non-conforming" gender behavior is punished, and "gender appropriate" behavior is rewarded. See Carolyn Lochhead, *Conservatives Brand Homosexuality a 'Tragic Affliction'*, S.F. CHRON., June 20, 1997, at A4.

140. "[T]he current literature and the vast majority of scholars in this field state that one's sexual orientation is not a choice, that is, individuals no more choose to be homosexual than heterosexual." Roberta K. Beach, *Homosexuality and Adolescence*, 92 PEDIATRICS 631, 631 (1993) (citations omitted). Cf. Socarides, *supra* note 134 ("For more than 20 years, I and a few of my colleagues in the field of psychoanalysis have felt like an embattled minority, because we have continued to insist, against today's conventional wisdom, that gays aren't born that way.").

141. Richard Green, *Gender Identity Disorder in Children*, in TREATMENTS OF PSYCHIATRIC DISORDERS 2001, 2002 (Glen O. Gabbard ed., 1995).

142. RICHARD GREEN, THE "SISSY BOY SYNDROME" AND THE DEVELOPMENT OF HOMOSEXUALITY 370 (1987).

143. PHYLLIS BURKE, GENDER SHOCK 32-33 (1996).

worthwhile and workable goal with motivated families. Perhaps if Western culture accommodated gender-deviant children . . . intervention would be unwarranted.¹⁴⁴

Some health professionals go further than Dr. Green in their assessment of the therapeutic needs of gay youth. One professional asserts that "[t]he psychosocial problems of gay and lesbian adolescents are primarily the result of societal stigma, hostility, hatred, and isolation."¹⁴⁵ These health professionals direct their therapeutic attention to helping gay youth come to terms with their sexual orientation, rather than changing them into heterosexuals.¹⁴⁶ For youth who have confusion about or are questioning their sexual orientation, counseling to help them through this process is appropriate.¹⁴⁷

Given both societal ambivalence about homosexuality and the medical profession's changing views about homosexuality and GID, it is understandable that gay or questioning adolescents have difficulty reconciling the mixed messages they receive. Adolescence is a time when many children struggle with sexual identity issues.¹⁴⁸ It is a time when some children may first feel "different" from their "normal" heterosexual peers.¹⁴⁹ They may report feelings of homosexuality, bisexuality, transgenderism, or confusion about sexuality.¹⁵⁰ Many of these children face severe harassment and ridicule at school or home which only exacerbates their confusion.¹⁵¹ Few schools, churches, communities, and families are equipped to help them during this "coming out" process. Parents, family, classmates, teachers, and counselors may be sources of support, but are more often sources of conflict, if not harassment, belittlement, and/or hostility.¹⁵² Because of the lack of acceptance, gay adolescents are even more susceptible than other adolescents to depression and behavioral or

144. Green, *supra* note 141, at 2014.

145. Beach, *supra* note 140, at 632 (citations omitted).

146. *See id.* at 633.

147. *See id.*

148. *See* Gary Remafedi et al., *Demography of Sexual Orientation in Adolescents*, 89 PEDIATRICS 714, 714-21 (1992). A study of 36,741 Minnesota public school students, grades 7 through 12 was conducted. 25.9% of 12-year-olds, compared to 5% of 18-year-olds described themselves as "unsure" of their sexual orientation. *Id.* at 716. "Gay and lesbian adolescents share many of the developmental tasks of their heterosexual peers. These include establishing a sexual identity and deciding on sexual behaviors . . ." Beach, *supra* note 140, at 631.

149. "Developmental research suggests that most adults recognize their lesbian or gay sexual orientation in early adolescence, although many do not label themselves or act upon their feelings until later." D'Augelli & Hershberger, *supra* note 93, at 422 (citations omitted).

150. *See id.* (although no studies of transgenderism were located).

151. *See id.* at 423; *see also supra* note 94.

152. *See id.* at 423; *see also* Sonia Renee Martin, *A Child's Right to Be Gay: Addressing the Emotional Maltreatment of Queer Youth*, 48 HASTINGS L. J. 167, 169-74 (1996).

emotional difficulties.¹⁵³ Alarming, the suicide rate for gay adolescents is two to three times higher than for straight adolescents, and may account for up to 30% of completed youth suicides each year.¹⁵⁴

Alternatively, children struggling with these feelings and lack of acceptance may well engage in "acting out" behavior. This behavior could result in a diagnosis of oppositional defiant disorder, or other behavior-related disorders.¹⁵⁵ However, there is no medical evidence that such actions or symptoms are caused by homosexuality, as opposed to a reaction to hostile external forces.¹⁵⁶

Some parents become desperate to find solutions to these concerns, especially because they are particularly troubled by the fact that their child is reporting what to them is an abnormal sexual orientation. When faced with youth struggling with these issues, some parents choose to civilly commit their children for inpatient psychiatric care. That care may be sought in order to "cure" the homosexuality, to "cure" the "acting out" or other behavior caused by the conflicts at home or school, or to "cure" other symptoms like depression. While appropriate treatment for suicidal behavior and severe depression *may* include inpatient treatment, such treatment for other conditions should be viewed with great skepticism in light of medical uncertainties surrounding homosexuality, generally, and treatment for GID,¹⁵⁷ specifically. Stronger standards and

153. See D'Augelli & Hershberger, *supra* note 93, at 423-24. "Abusive treatment in schools often results in declining academic performance, absenteeism, or dropping out for gay and lesbian students. Internalized homophobia may act in concert with external abuse to heighten the victim's sense of differentness, helplessness, guilt, and shame. Severe anxiety, depression, and self-destructive acts may ensue." Gary Remafedi, *Fundamental Issues in the Care of Homosexual Youth*, 74 MED. CLINICS N. AM. 1169, 1172 (1990).

154. See Gary Remafedi et al., *Risk Factors for Attempted Suicide in Gay and Bisexual Youth*, 87 PEDIATRICS 869, 869 (1991) (quoting U. S. Dept. Health & Hum. Serv., *Prevention and Intervention in Youth Suicides*, in 3 REP. OF THE SECRETARY'S TASK FORCE ON YOUTH SUICIDE (1989)).

155. See *infra* notes 159-63 and accompanying text.

156. See *supra* note 145 and accompanying text. "[N]umerous investigations involving male homosexual adults have failed to reveal [that underlying characterologic and/or emotional disorders may predispose homosexual and bisexual adolescents to psychosocial dysfunction]." Gary Remafedi, *Adolescent Homosexuality: Psychosocial and Medical Implications*, 79 PEDIATRICS 331, 336 (1987).

157. It is clear that despite the controversy within the medical profession, treatment for GID is still given. A recent article reported results of a survey of the ten most populous states regarding the number of children or adults who were diagnosed with GID under the states' Medicaid programs. Medicaid is a federal government health care program for indigent persons. For Fiscal Year ("FY") 1995, New York reported that 66 children and 76 adults or adolescents were diagnosed with GID. In FY 1996, 55 children and 73 adults or adolescents were diagnosed. In Florida, in FY 1995, 2 children, and 1 adult or adolescent were diagnosed; in FY 1996, 6 children, and 2 adults or adolescents were diagnosed. The results from other states were not as certain. *An Attack on Our Most Vulnerable: The Use and Abuse of Gender Identity Disorder*, LESBIAN & GAY N.Y., Oct. 28, 1997, at 25.

procedures are therefore necessary to ensure that the problems experienced by the minor are accurately assessed and that medical treatment is appropriate.

c. Vague diagnoses can be the basis for inpatient admissions

In addition to the lack of helpful admission criteria for juveniles, some mental health diagnosis criteria for children are also quite vague and overly broad. An example of this is the diagnosis of Oppositional Defiant Disorder ("ODD").¹⁵⁸ This diagnosis is one of a number of "personality disorders" which are often used as a basis for admitting juveniles for inpatient care.¹⁵⁹ This diagnosis requires a "recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures that persists for at least six months."¹⁶⁰ It is further

characterized by the frequent occurrence of at least four of the following behaviors: losing temper, arguing with adults, actively defying or refusing to comply with the requests or rules of adults, deliberately doing things that will annoy other people, blaming others for his or her own mistakes or misbehavior, being touchy or easily annoyed by others, being angry and resentful, or being spiteful or vindictive.¹⁶¹

Finally, to meet the diagnosis for ODD, "the behaviors must occur more frequently than is typically observed in individuals of comparable age and developmental level and must lead to significant impairment in social, academic, or occupational functioning."¹⁶² Weithorn points out that some researchers deem this behavior normal, as a part of growing up, and some research suggests that in a large percentage of cases, the presence of such behavior is transitory.¹⁶³ So, while an ODD diagnosis may meet the "mental disorder" standard required under *Parham* or

158. This was one of the diagnoses used to justify Lyn Duff's commitment. See *infra* notes 216-18 and accompanying text.

159. See Weithorn, *supra* note 121, at 789. This is borne out by data available in California. The California Office of Statewide Health Planning and Development discharge data for 1990 and 1995 was analyzed. See *infra* note 222. In 1990, there were 9621 patients, 13 years old or younger, who were admitted to a facility with a primary or secondary diagnosis with a psychiatric basis. Of these 9621 cases, 983 had an ODD diagnosis. In 1990, there were 18,225 patients, 14 to 17 years old, who were admitted to a facility with a primary or secondary diagnosis with a psychiatric basis. Of these 18,225 cases, 1104 had an ODD diagnosis. The data for 1995 was 8165 cases, 13 or younger, 706 with an ODD diagnosis, and 19,655 patients, 14 to 17, 1075 with an ODD diagnosis. ODD was the sixth most frequent psychiatric diagnosis in 1990, and the eighth most frequent in 1995. See *infra* note 222.

160. DSM-IV at 91.

161. *Id.*

162. *Id.*

163. See Weithorn, *supra* note 121, at 790-91.

Roger S., it does not constitute the severe or acute mental illness standard required for adult, juvenile ward or dependent inpatient admissions.¹⁶⁴

Because of rejection or abuse, gay or questioning youth may well engage in behavior which could be characterized as meeting an ODD diagnosis. For example, many gay youth run away from home or have conflicts with the law.¹⁶⁵ These behaviors could meet the pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures specified in the ODD diagnosis. However, that does not mean that inpatient commitment is necessarily an appropriate response.

A similar analysis follows if a minor is diagnosed with depression. In reviewing the symptoms of "Major Depressive Episode" in the DSM, it is conceivable that many adolescents, especially those facing rejection and belittlement because of their homosexuality, could be diagnosed as meeting its criteria.¹⁶⁶ Among minors in California, the most frequently made diagnoses supporting inpatient admissions are based on depression or related diagnoses.¹⁶⁷ Depression is a frequently occurring symptom of gay children,¹⁶⁸ and many could be diagnosed as meeting the DSM definition of a major depressive episode. As such, they could be admitted for inpatient care on the basis of such a diagnosis. As with the ODD diagnosis, however, inpatient treatment is not necessarily an appropriate option. Without stronger protections, however, improper inpatient admissions will continue to occur.

164. See *supra* notes 6-25 and accompanying text.

165. See Remafedi, *supra* note 156, at 336.

166. The essential feature of a Major Depressive Episode is a period of at least two weeks during which there is either a depressed mood or a loss of interest or pleasure in nearly all activities. In children and adolescents, the mood may be irritable rather than sad. The individual must also experience at least four additional symptoms drawn from a list that includes changes in appetite or weight, sleep and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation, plans, or attempts. To count toward a Major Depressive Episode, a symptom must either be newly present or must have clearly worsened compared with the person's preepisode status. The symptoms must persist for most of the day, nearly every day, for at least two consecutive weeks. See DSM-IV at 320.

167. For example, the California Office of Statewide Health Planning and Development data for 1995 showed that the most frequent diagnoses for inpatient admissions for 14-17 year olds, based on a psychiatric diagnosis, were depressive disorder (3069), major depressive disorder (2083), major depressive disorder, severe (1687), neurotic depression (1490), and major depressive disorder, recurrent, severe (1161). These diagnoses represented five of the top eight diagnoses. The numbers in parentheses represent the number of occurrences of the diagnosis among 19,655 total admissions. Multiple diagnoses were not eliminated, so that the numbers do not represent the number of individuals admitted for a specified diagnosis. The data for 1990 is similar. See *infra* note 222.

168. See *supra* notes 153, 154.

(2) *Assumption that Parents Will Act in Best Interests of Children*

Both *Parham* and *Roger S.* assumed that parents will act in the best interests of their children out of love and affection. "[H]istorically, [the law] has recognized that natural bonds of affection lead parents to act in the best interest of their children."¹⁶⁹ "We emphasize here our assumption that the great majority of parents are well motivated and act in what they reasonably perceive to be the best interest of their children."¹⁷⁰ Therefore, parental decisions and the right of parents to make decisions affecting their children receive great deference from the courts.

Critics of the view that parents will act in the best interests of their children cite the realities of the family situations which are typical when a commitment decision is being contemplated. Parents are at their wit's end, and are, in essence, prepared to abdicate their parental authority to the state.¹⁷¹

Because parents rarely are mental health professionals and also because their concerns must include the well-being of the family as a whole rather than solely the child, commitment decisions often are made based upon a misunderstanding of the child's behaviors and/or a desire to do what is best for the family. Parents' perceptions also may be distorted. Parents may use the child as the family scapegoat, blaming all family problems on the child's behavior. The family itself may be dysfunctional, with many children facing commitment coming from dysfunctional families. A disturbed family system may be partly responsible for the child's bizarre behaviors which, in turn, causes the parent to misinterpret the child's behaviors and needs. Often, a child's problems cannot be meaningfully separated from those of the family. The child's behavior may reflect adaptation to a home environment which does not provide for him or her adequately.¹⁷²

A corollary of the assumption that parents act in the best interests of their children is that harm to the parent-child relationship will occur if the court interferes with parental decisions.

Another problem with requiring a formalized, factfinding hearing lies in the danger it poses for significant intrusion into the parent-child relationship. Pitting the parents and child as adversaries often will be at odds with the presumption that parents act in the best interests of their

169. *Parham v. J.R.*, 442 U.S. 584, 602 (1979) (citations omitted).

170. *In re Roger S.*, 569 P.2d 1286, 1295 (Cal. 1977).

171. See Garvey, *supra* note 116, at 810-11 (persuasively arguing that the distinctions made between liberty interests of adults and children are unwarranted, and that, therefore, the same procedural due process protections ought to attach for children and adults facing civil commitment).

172. DUE PROCESS PROTECTIONS FOR JUVENILES IN CIVIL COMMITMENT PROCEEDINGS 5-6 (Richard E. Redding et al. eds., 1991). See also Ellis, *supra* note 116, at 857-62; Shoenberger, *supra* note 116, at 7 n.39.

child. . . . Surely, there is a risk that it would exacerbate whatever tensions already exist between the child and the parents.¹⁷³

The *Roger S.* opinion had the opposite perspective on this potential problem, finding that "such recognition of the child's right to due process in proceedings to admit him to a state mental hospital [would not] necessarily weaken the family unit. The contrary may be true."¹⁷⁴

These intrafamilial dynamics are of particular concern for gay youth. When parents first learn that their children are gay, they are often emotionally devastated, feel great shame or anger and feel great isolation—feelings which parallel those experienced by their children.¹⁷⁵ Gay children report that they do not feel comfortable revealing their sexual orientation to their parents because they fear punishment, rejection or being disowned by their parents or families.¹⁷⁶ Parents may seek commitment to change a child's sexual orientation even if there is no recognized and appropriate mental "disorder." Such a decision may stem from parental fear, disapproval, anger or shame, rather than the child's best interests.

173. *Parham*, 442 U.S. at 610.

174. *Roger S.*, 569 P.2d at 1291 (citing *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52 (1976), for the proposition that when a minor seeks an abortion, the parent and minor are fundamentally in conflict).

175.

It is an exceptional parent who can provide appropriate support and guidance for gay children without assistance. Most parents need information about homosexuality. The myth that blames parents for a child's homosexuality should be directly confronted and replaced by more reliable information. Most parents need to grieve the loss of their child's heterosexual identity and the anticipated loss of their own identity as grandparents, before they can accept their son's or daughter's homosexuality.

Remafedi, *supra* note 153, at 1175-76.

176.

[A]vailable anecdotal and empirical reports underscore substantial challenges to adjustment for lesbian, gay, and bisexual youth. In general, openness to others about sexual orientation is associated with better psychological adjustment, although there are risks associated with such disclosures. The process of disclosure or coming-out is generally an emotionally difficult one, but it is worsened by negative reactions from significant others such as family and friends, and by discrimination, harassment and violence directed to lesbians, gay males, and bisexual people. For lesbian, gay, or bisexual adolescents, risks of rejection from peers and from family members are particularly important. Remafedi found that 41% of his gay male sample had lost at least one friend because of sexual orientation. In addition, only 21% of mothers and 10% of fathers who were told of their sons' sexual orientation were perceived to be supportive. In a university sample of gay males, D'Augelli found that 26% of mothers and 57% of fathers were seen as intolerant or rejecting after their offsprings' disclosure of their sexual orientation. Verbal harassment of open young lesbians, gay males, and bisexuals occurs frequently; physical assault also occurs, especially in urban areas.

D'Augelli & Hershberger, *supra* note 93, at 423 (citations omitted).

It is true that most parents act in their children's best interests in making health treatment decisions on their behalf. Nevertheless, both *Parham* and *Roger S.* failed to recognize that when parents face the decision to commit their children, their judgment may be clouded by extreme emotional and intrafamilial circumstances, especially when parents are coming to terms with their children's differing sexual orientation or low conformity to gender norms.

(3) *Assumption that Physician Will Act in Best Interests of Children*

Parham assumed that physicians will act in the best interests of children. "We are satisfied that the voluminous record as a whole supports the conclusion that the admissions staffs of the hospitals have acted in a neutral and detached fashion in making medical judgments in the best interests of the children."¹⁷⁷ *Roger S.*, on the other hand, noted that in the case before it, several physicians and a psychologist had reached "diametrically opposed views [in] . . . precommitment and postadmission evaluation[s]."¹⁷⁸ Thus, while not addressing the issue of physician bias, *Roger S.* did express concern about the potential for erroneous diagnosis.

Along similar lines, some commentators believe that physicians may act on behalf of parents as opposed to children.¹⁷⁹ After all, the parents are usually the person with whom the physician has the most contact and it is the parents who seek advice and relief from the demands of their children and who may directly or indirectly foot the bill for the treatment.

For gay youth in particular, the issue of whether the therapist is acting in their or their parents' interests is a very real one. One of the justifications for treatment of GID in children is to address "appropriate parental concern over gender deviance."¹⁸⁰ This is a questionable justification, given that treatment should be aimed at the needs of the "sick" person, not at those of his or her parents.

The issue of physician bias was also raised in *American Academy of Pediatrics*. The State contended, in supporting the constitutionality of the

177. *Parham*, 442 U.S. at 616.

178. *Roger S.*, 569 P.2d at 1295.

179.

When a parent seeking to have a child committed goes to a hospital official or a private psychiatrist, however, the psychiatrist's position becomes less clear-cut. In the case of a juvenile voluntary patient, the legal volition involved is that of the parent. While the goal of the psychiatrist will be expressed—and perceived—as the best welfare of the child-patient, it is the parent who has come to seek help, whose situation seems most desperate, who seems the most reliable source of information about what is wrong, who is closest to the psychiatrist in age and social outlook, and who is paying the psychiatrist's fee.

Ellis, *supra* note 116, at 867-68.

180. See Rekers, *supra* note 134.

statute at issue, that the judicial bypass was justified by the State's interest in ensuring that the determination whether a minor is competent and mature enough to consent to an abortion is made in a fair and unbiased manner.¹⁸¹ The plurality disagreed and found that "[n]othing in the record justifies an assumption that licensed health care providers cannot be trusted to make an unbiased determination as to whether a minor is capable of giving informed consent to an abortion"¹⁸² In arguments which echo those made by critics of *Parham*, Justice Mosk pointed out in his dissent that

In any individual case, factors beyond mere medical judgment may weigh in favor of, or against, an abortion. A parent may offer a more complete and accurate perspective on those factors than a physician; so also might a neutral juvenile court judge in a bypass procedure. Further, unlike a parent acting in the unemancipated minor's overall best interest or a neutral judge, a physician may have a "direct, personal, substantial, pecuniary interest in reaching a conclusion," or a personal bias in favor of—or against—abortion.¹⁸³

Thus, both the plurality and Justice Mosk were cognizant of the issue, and recognized the need to examine whether a physician can exercise decision-making power without undue bias. The plurality was convinced that in the abortion context there was no evidence that such bias existed. Nevertheless, *Roger S.* found the possibility of physician bias to be a very real one in the commitment context.

As noted by Justice Mosk, physician bias may take the form of financial self-interest. In the 1980s, there was evidence that some health care providers had financial motives for the treatment recommendations they made. There are convincing facts which show growing populations of children are being "treated" in inpatient settings, thus raising the concern that the recommendations to commit these children were not made with the interests of the children in mind.¹⁸⁴ Over the last sixty years, there has been a steep increase in the admission rates of minors as well as a significant shift from public to private placements.¹⁸⁵ For instance, between 1980 and 1984 national juvenile admissions to private psychiatric hospitals increased more than fourfold.¹⁸⁶ There was also a parallel increase in the number of private psychiatric hospitals around the same

181. *American Academy of Pediatrics v. Lungren*, 940 P.2d 797, 860 (Cal. 1997) (Mosk, J., dissenting).

182. *Id.* at 830.

183. *Id.* at 860 (Mosk, J., dissenting) (citation omitted).

184. *See* Weithorn, *supra* note 121, at 783.

185. *See id.* (citing *Emerging Trends in Mental Health Care for Adolescents: Hearings Before the House Select Comm. on Children, Youth, and Families*, 99th Cong., 1st Sess. 5 (1985)).

186. *See id.* This statistic was not adjusted to account for population change, but the population of persons under 18 decreased 1.6% from 1980-84.

time.¹⁸⁷ Free-standing facilities increased 35% from 1985 to 1987 and psychiatric wards in general hospitals increased 49%.¹⁸⁸

The combination of the facts that psychiatric hospitals are relatively inexpensive to operate (because relatively small numbers of psychiatrists can oversee the treatment of large numbers of patients); the fact that many health insurance policies will pay large reimbursement rates for inpatient psychiatric care, even on a short-term basis; and that many health insurance policies limit coverage for outpatient psychiatric care, all combine to favor the economics of inpatient psychiatric care.¹⁸⁹

Indications are that these trends are reversing somewhat in the 1990s.¹⁹⁰ The combination of highly publicized scandals in the mental health care industry,¹⁹¹ governmental investigations,¹⁹² media coverage,¹⁹³ and a substantial move toward managed care¹⁹⁴ has resulted in dramatic decreases in the provision of mental health services. Nevertheless, large numbers of children continue to be admitted for inpatient psychiatric care,¹⁹⁵ some number of whom are undoubtedly admitted because of their sexual orientation or low conformity to gender norms.

The issue of physician bias is particularly relevant for gay youth. While homosexuality has been declassified as a mental disorder by the

187. See *id.* at 816-17.

188. See *id.* at 816-17.

189. See *id.* at 816-17.

190. See Mark Smith, *Mental Health Managed Care Brings Concerns: Financial Limits Blamed for Shorter In-Patient Stays*, HOUSTON CHRON., Mar. 23, 1997, at A1.

191.

In a major case, California-based National Medical Enterprises paid a record \$379 million in fines, penalties and civil damages on behalf of its psychiatric hospital subsidiary The NME subsidiary pleaded guilty to a kickback scheme in which physicians and others were paid to refer patients to its psychiatric hospitals.

Id.

192. See "The Profits of Misery: How Inpatient Psychiatric Treatment Bilks the System and Betrays Our Trust," *Hearings before the Select Committee on Children, Youth, and Families*, 102nd Congress, Second Session, 138 Cong. Rec. D456-01 (1992); Peter Kerr, *U. S. Study of Mental Care Finds Widespread Abuses*, N.Y. TIMES, Apr. 29, 1992, at D1 (reporting that "[a] Federal Government review of private psychiatric hospital cases—most of them teen-agers and young children of military families—has found that in 64 percent of the cases patients never should have been admitted, were kept longer than necessary or had medical records for which their hospitals could not justify treatment."); UNITED STATES GENERAL ACCOUNTING OFFICE, JUVENILE JUSTICE — ADMISSIONS OF MINORS WITH PREADULT DISORDERS TO PRIVATE PSYCHIATRIC HOSPITALS, GAO/GGD 94-167FS (1994).

193. See JOE SHARKEY, *BEDLAM: GREED, PROFITEERING, AND FRAUD IN A MENTAL HEALTH SYSTEM GONE CRAZY* (1994).

194. "Without question, managed care has led to quantifiable changes in mental health care. The average private hospital stay for psychiatric treatment, for example, has dropped from 26 days nationwide in 1990 to less than 10 days now." Smith, *supra* note 190, at A1.

195. For example, data in California shows large numbers of minors being admitted for inpatient care based on psychiatric diagnoses. See *supra* note 159.

American Psychiatric Association,¹⁹⁶ some therapists continue to believe that homosexuality is a mental disorder and *continue* to offer reparative therapy as a way to prevent homosexuality.¹⁹⁷ The efficacy of reparative therapy has recently been questioned by the American Psychological Association.¹⁹⁸ As noted above, these controversies are reflective of a more generalized societal ambivalence about homosexuality.¹⁹⁹ As such, there is a high degree of probability, in the context of commitments involving a gay minor, that "licensed health care providers cannot be trusted to make an unbiased determination" as to the minor's best interests.

(4) *Assumption that Benefits of Inpatient Care Outweigh Harms*

Parham and *Roger S.* seemed to acknowledge the trauma and loss of freedom that result from inpatient commitment. *Parham* acknowledged that "a child . . . has a substantial liberty interest in not being confined unnecessarily for medical treatment."²⁰⁰ *Roger S.* acknowledged that "[t]he consequences of confining a person, minor or adult, involuntarily in a mental hospital are quite different and impinge much more directly on the liberty interest of the patient than does confinement for treatment of physical illness."²⁰¹ However, *Parham* and *Roger S.* failed to acknowledge that less drastic forms of treatment might better serve the af-

196. See *supra* text accompanying note 124.

197.

Every day young men seek help because they are experiencing an unwanted sexual attraction to other men, and are told that their condition is untreatable. It is not surprising that many of these young men fall into depression or despair when they are informed that a normal life with a wife and children is never to be theirs Young men and the parents of at-risk males have a right to know that prevention and effective treatment are available.

Charles Socarides et al., *Don't Forsake Homosexuals Who Want Help*, WALL ST. J., Jan. 9, 1997, at A12. See also *supra* notes 138-39.

198. See David Tuller, *Psychologists Oppose "Conversion" Therapy for Gays*, S.F. CHRON., Aug. 15, 1997, at A3 (reporting that "[t]he American Psychological Association voted yesterday to discourage controversial therapies that seek to change a person's sexual orientation."). In a carefully worded resolution, the American Psychological Association Council of Representatives recognized that gay, lesbian, bisexual, and questioning individuals are "at risk for presenting for 'conversion' treatment [treatment to change sexual orientation] due to family or social coercion and/or lack of information." American Psychological Association Council of Representatives, *Resolution on Appropriate Therapeutic Responses to Sexual Orientation* (visited Feb. 20, 1998) <http://psychology.ucdavis.edu/rainbow/html/resolution97_text.html>. The resolution goes on to state that "psychologists [should] not make false or deceptive statements concerning . . . the scientific or clinical basis for . . . their services" and that "psychologists [should] attempt to identify situations in which particular interventions . . . may not be applicable . . . because of factors such as . . . sexual orientation." *Id.*

199. See *supra* Part II.A.

200. *Parham v. J.R.*, 442 U.S. 584, 600 (1979).

201. *Roger S.*, 569 P.2d at 1290.

fectured children. Studies have shown that cure rates in inpatient settings are quite low, and that treatment in community-based settings may obtain better results.²⁰² This, combined with the generally restrictive settings, indicates that for most patients inpatient care is the least desirable form of treatment.

In addition, the stigma of hospitalization in mental institutions still exists. *Parham* understood the weight of this stigma:

We . . . recognize that commitment sometimes produces adverse social consequences for the child because of the reaction of some to the discovery that the child has received psychiatric care. . . . This reaction, however, need not be equated with the community response resulting from being labeled by the state as delinquent, criminal, or mentally ill and possibly dangerous. The state through its voluntary commitment procedures does not "label" the child; it provides a diagnosis and treatment that medical specialists conclude the child requires. In terms of public reaction, the child who exhibits abnormal behavior may be seriously injured by an erroneous decision not to commit. Appellees overlook a significant source of the public reaction to the mentally ill, for what is truly "stigmatizing" is the symptomatology of a mental or emotional illness.²⁰³

In contrast, *Roger S.* recognized the child's interest in avoiding the stigma, "[n]ot only is there physical restraint, but there is injury to protected interests in reputation, an interest in not being improperly or unfairly stigmatized as mentally ill or disordered."²⁰⁴

In addition, there are demonstrable long-term negative effects from prolonged inpatient treatment in terms of transitional and readjustment difficulties, not to mention the trauma of the treatment itself.²⁰⁵ Further, attempts to "cure" sexual orientation may do more harm than good.²⁰⁶ Moreover, there are other demonstrable consequences of inpatient treatment such as lost educational opportunities, inability to socialize in non-institutional settings, and the loss of potential career opportunities.²⁰⁷ De-

202. "Despite the fact that it is the most costly and restrictive type of mental health treatment, ' . . . the effectiveness of psychiatric hospitalization for treating childhood mental disorders has not been systematically studied.'" Ira M. Schwartz, *Hospitalization of Adolescents for Psychiatric and Substance Abuse Treatment*, 10 J. ADOLESCENT HEALTH CARE 473, 474 (1989). "Early empirical findings suggest that certain family-oriented and community-based programs are quite successful at alleviating a range of serious or disturbing child, adolescent, and family problems." Weithorn, *supra* note 121, at 788.

203. *Parham*, 442 U.S. at 600-01 (citations omitted).

204. *Roger S.*, 569 P.2d at 1291-92 (citations omitted).

205. See Weithorn, *supra* note 121, at 796-97.

206. See *supra* note 198. "Therapy directed specifically at changing sexual orientation is contraindicated, since it can provoke guilt and anxiety while having little or no potential for achieving changes in orientation." Beach, *supra* note 140, at 633.

207. See Weithorn, *supra* note 121, at 796-97.

spite these concerns, however, the courts left it to medical personnel to make and review the commitment decision.

(5) *Assumption that Parents Have Better Capacity than Children for Good Decision Making*

Children have a greater capacity to make good decisions for themselves than the law accepts. In *Roger S.*, the court stated that "14 years is the appropriate age at which [children's right to assert their right to due process independently when opposed to a parental decision to institutionalize] must be recognized."²⁰⁸ On the other hand, *Parham* found that

the law's concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions. . . . Most children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment.²⁰⁹

Critics of this assumption have pointed to the abortion cases in which minors' right to choose an abortion cannot be unreasonably constrained.²¹⁰ Studies have also demonstrated that minors are capable of making sound decisions on their own behalf.²¹¹ Children who are demonstrably able to make good decisions for themselves should be able to do so.

The assumption that parents are in a better position to "choose" the appropriate medical treatment than their children is especially suspect where a child is struggling with options that may be totally foreign to the parents, and where the biological or psychological considerations may be outside the experiences of the parents. Parents are undoubtedly struggling with their children's sexual orientation. This could result in decision-making which is clouded by unfounded fears or biases, rather than what is in the minor's best interests.

D. Case Studies

There is some anecdotal information about cases involving institutionalization of children because of their sexual orientation.²¹² Compre-

208. *Roger S.*, 569 P.2d at 1297.

209. *Parham*, 442 U.S. at 602-03.

210. See Butler, *supra* note 116, at 1285.

211. See, e.g., Lois A. Weithorn, *Children's Capacities in Legal Contexts*, in CHILDREN, MENTAL HEALTH AND THE LAW 25-55 (N. Dickson Reppucci et al. eds., 1987)(citing studies); see also GARY B. MELTON ET AL., CHILDREN'S COMPETENCE TO CONSENT (1983).

212. See *supra* references in note 2; see generally PHYLLIS BURKE, GENDER SHOCK (1996) (reporting on an 11-year-old girl who was hospitalized for depression and GID); Bruce Mirken, *Setting Them Straight*, 10 PERCENT, June 1994, at 54 (the story of a 14-year-old who spent 45

hensive data has not been found, and there appear to be no studies to determine the pervasiveness of this problem.²¹³

A couple of examples are telling. Daphne Scholinski survived an ordeal lasting four years in an institution. Since then she has spent many years trying to recover from the horrors she suffered there. She relates these horrors elsewhere in this issue.²¹⁴ One of the reasons she was committed was that she did not act like a "sexual female."²¹⁵ As a result, she was labeled as having a sexual identity problem, and was institutionalized for treatment of this "problem."

In 1991, a fifteen year old named Lyn Duff was diagnosed with ODD, Sexual Identity Disorder, and GID.²¹⁶ Though residing in California, Lyn was admitted to a facility called Rivendell in Utah where she was forcibly taken by her mother through the use of an "escort" service.²¹⁷ Rivendell advertised that it could "help kids work out their problems."²¹⁸

While at Rivendell she underwent various forms of behavior modification. She was locked in seclusion rooms, was administered drugs, and

days at Rivendell after his parents caught him having sex with a boy. His treatment included having electrodes attached to his penis and receiving electric shocks if he became aroused by pictures of men.); Bob Gardinier, *Four Winds Pickets Claim Mistreatment of Youths, Gays*, TIMES UNION (Albany), June 4, 1996, at B10 (reporting on alleged use of aversion therapy to "treat" gay and lesbian youth); Mark Smith, *Profitable Addictions; Marketing Ploys or Medical Need?; Wealth of new programs raises questions*, HOUSTON CHRON., Dec. 8, 1991, at 1 (examining marketing by private psychiatric hospitals in Texas which includes treatment for sexual disorders; also relating testimony by a young man before a Texas State Senate committee who had been hospitalized for two-and-a-half years because his mother did not want to deal with his gayness. He also testified that there were at least ten other minors there who were also institutionalized because they were gay.); Natalie Angier, *The Biology of What it Means to be Gay*, N.Y. TIMES, Sept. 1, 1991, at 4-1 (describing a social service agency's experience with a 12-year-old boy who was sent to a psychiatric hospital by his mother when he told her he was gay); TWO TEENAGERS IN TWENTY: WRITINGS BY GAY AND LESBIAN YOUTH 51 (Ann Heron ed., 1984) (writings by teenagers including several who had spent time in lock-up facilities and psychiatric hospitals).

213. See *supra* note 2.

214. Daphne Scholinski, *After-Wards*, 48 HASTINGS L.J. 1195 (1997). Ms. Scholinski has recently published a book detailing her experiences. DAPHNE SCHOLINSKI WITH JANE MEREDITH ADAMS, *THE LAST TIME I WORE A DRESS* (1997).

215. See Scholinski, *After-Wards*, *supra* note 214, at 1195.

216. See Lyn Duff, *I Was a Teenage Test Case*, 16 CAL. J. 5, 46 (1996); Elizabeth Fernandez, *Girl "divorces" mom for gay guardians*, S.F. EXAMINER, Feb. 22, 1993, at A1; BURKE, *supra* note 212, at 93-95.

217. See Duff, *supra* note 216, at 46.

218. See, e.g., *Rivendell Advertisement*, SUNSET, Nov. 1991, at 255. Copies of advertisements for Rivendell appearing in *Sunset* magazine in 1991 on file with *Hastings Law Journal*. Advertisements in 1997 for Rivendell and its successor, Copper Hills Youth Center, state that it treats "sexual impulse disorders."

participated in group sessions with other girls where they discussed dresses and makeup.²¹⁹ This lasted for 178 days.²²⁰

Daphne and Lyn survived their ordeals, however both of them strongly believe that their institutionalization was wrong, actively harmed them, and that what happened to them should not happen to others.

E. Need for Additional Data

It would be useful if data about LPS, *Roger S.* and S.B. 595 commitments could be compared. Unfortunately, LPS and *Roger S.* data is not required to be collected, and the data is not maintained by either the State of California Department of Mental Health ("DMH") or Patients' Rights Advocates, so no studies analyzing the different procedures are available.²²¹

In the absence of such reporting requirements, I have attempted to collect raw data for analysis. First, I obtained discharge data. The State of California Office of Statewide Health Planning and Development ("OSHPD") collects data reported by both public and private hospitals throughout the state.²²² The data includes information about all inpatient admissions, including the nature of the primary and secondary admitting diagnoses. Unfortunately, this data does not indicate the reason for discharge (e.g., whether the patient requested a review and was subsequently released through the review process or whether the patient was released after treatment).

In 1991, the California Association of Mental Health Patients' Rights Advocates ("CAMPHRA") submitted statistics in support of proposed post-*Roger S.* legislation which indicated that in 1990 the release rate as a result of *Roger S.* due process procedures in the public system was one release per 15 admissions.²²³ CAMPHRA indicated that the release rate as a result of the clinical review in the private system was one release per 290 admissions in 1990. The source of the data could not be

219. See Duff, *supra* note 216, at 46.

220. See *id.*

221. An extensive review of the legal and medical literature uncovered no studies of data analyzing commitment of children for inpatient care.

222. Under California Health and Safety Code § 443.31(g) (1990) (repealed 1995), each county and private facility had to provide annual patient discharge data. State hospitals are not required to report. Disks containing data for 1990 and 1995 were obtained from OSHPD and are on file with the author.

223. *Assembly Comm. on Health*, A.B. 1276 (Apr. 23, 1991).

confirmed.²²⁴ Nevertheless, there was evidence that compliance with S.B. 595 was very sporadic and resulted in low release rates in 1990.²²⁵

Private facilities are required to provide information including the "number of minors admitted by diagnosis, length of stay, and source of payment, the number of requests for an independent clinical review by diagnosis, source of payment, and outcome of the independent clinical review" to DMH on an annual basis.²²⁶ I obtained all available data from DMH.²²⁷ The data was incomplete.²²⁸ Data for 1995 was the most complete with eleven facilities reporting.²²⁹ Among these eleven facilities, a total of 2127 patients between fourteen and seventeen years old were reported admitted. Of these patients, 151 (7% of total admissions) requested an independent clinical review (one review was apparently requested by MediCal). Of these 151 patients, 82 (54% of those requesting review) subsequently rescinded their request for review; 34 (22%) were released before the review occurred; 7 (4.6%) were released after the review; and 28 (18.4%) were detained after review.

While it is difficult to draw final conclusions from this limited data, inasmuch as 59% of the reviews conducted resulted in releases, it strongly suggests that the review process prevents inappropriate commitments.²³⁰ It also raises disturbing questions about waivers and pressures exerted on minors, since 93% of the patients did not request reviews, and 54% of those requesting reviews withdrew their requests prior to the reviews.

224. CAMPHRA was contacted, but they were unable to provide the raw data on which these figures were based.

225. See Marc N. Sperber, *Short-Sheeting the Psychiatric Bed: State-Level Strategies to Curtail the Unnecessary Hospitalization of Adolescents in For-Profit Mental Health Facilities*, 13 AM. J.L. & MED. 251, 263-67 (1992) (detailing post-S.B. 595 compliance, and reporting low release rates ranging from three releases in 47 reviews, to two releases in 113 reviews).

226. CAL. WELF. & INST. CODE § 6002.40(c) (West, WESTLAW through 1997 portion of 1997-98 Reg. Sess. and 1st Ex. Sess.).

227. DMH is charged with the collection of and monitoring the compliance with the reporting requirement contained in California Welfare and Institutions Code § 6002.40(c) (West, WESTLAW through 1997 portion of 1997-98 Reg. Sess. and 1st Ex. Sess.). We were invited to review available reports at the offices of DMH in Sacramento.

228. A total of 13 reports were available and were photocopied.

229. According to the OSHPD discharge data, in 1990 there were 450 and in 1995 there were 418 facilities which admitted inpatient care patients 14-17 years old with a primary or secondary psychological diagnosis. This data does not include data from state hospitals, but does include data from county hospitals which are not subject to S.B. 595.

230. See also *infra* notes 242-49 and accompanying text describing similar results in the New Jersey review system.

III. Proposals

Dear Desperate, continued:

Gay, lesbian, bisexual, transgender, and questioning youth may be at higher risk of commitment than straight youth because sexuality issues will cause some parents and health practitioners to take drastic steps to get them "treated." The legal procedures I've described to you concern me because they don't adequately protect gay youth from potentially harmful hospitalization. This is particularly true for private hospitals. I hope that advocates will try to implement procedures which will require a meaningful process to consider what children need in order to get better and to prevent unnecessary and harmful "treatment." I also hope that they help develop alternative treatment placements so that gay youth who are having problems can obtain appropriate services.

I will now set forth six proposals which accomplish three different goals with the overall purpose of preventing improper inpatient psychiatric admissions of gay youth. The first goal is to strengthen the due process protections for gay youth. The first, third, fourth and fifth proposals address various aspects of current procedures, and suggest changes to better protect the interests of gay youth. The second goal is to expand the universe of possibilities for gay youth who interact with the mental health system. The second proposal suggests that the development of treatment alternatives is a way to accomplish this goal. Finally, the third goal is to increase the knowledge base so that future decisions can be made with the benefit of relevant and important data. The sixth proposal suggests avenues for additional data-gathering.

A. Standard of Review Encompassing LPS and "Least Restrictive Alternative" Standards

As previously discussed, different standards of review apply for juveniles facing commitment, depending on who is seeking to commit them, and whether the facility is public or private. For all adults, and for children who are wards of the state who object to commitment, the State has the burden to show that they are gravely disabled or that they pose a substantial risk of injury to themselves or others in order for the commitment order to be upheld.²³¹ For children facing commitment in a public hospital because of their parents' decision, *Roger S.* held that the purpose of the review process is to determine whether "the minor is mentally ill or disordered, and whether, if the minor is not gravely disabled or dangerous to himself or others as a result of mental illness or disorder,

231. CAL. WELF. & INST. CODE § 5256.5 (West 1984). However, only a showing of probable cause is necessary to justify a 72 hour commitment. See § 5150.

the admission sought is likely to benefit him.”²³² Finally, the standard of review for juveniles whose parents seek placement in a private inpatient setting is

whether the minor continues to have a mental disorder, whether further inpatient treatment is reasonably likely to be beneficial to the minor’s mental disorder, or whether the placement in the facility represents the least restrictive, most appropriate available setting, within the constraints of reasonably available services, facilities, resources, and financial support, in which to treat the minor.²³³

For gay youth, the lower standards of review applied in *Roger S.* and S.B. 595 proceedings make it much more likely that their commitment orders will be upheld when commitment is sought by their parents. This could happen in a number of ways. For example, since GID is listed as a mental disorder in the DSM, parents could seek to admit their child based on a GID diagnosis. Another likely scenario for gay youth involves a child’s failure to cooperate with treatment to modify sexual orientation. If the child acts defiantly, a parent could seek to have him or her admitted using an ODD diagnosis. For *Roger S.* admissions, a physician need only make the GID or ODD diagnosis and assert that the inpatient placement is likely to benefit the child. Similarly, for private placements, all that is needed is a GID or ODD diagnosis and an assertion that “further inpatient treatment is reasonably likely to be beneficial”²³⁴

Inappropriate commitments of gay youth could easily be prevented if the LPS “gravely disabled or substantial risk of injury” combined with the “least restrictive alternative” standard were imposed in both *Roger S.* and S.B. 595 reviews. The LPS standard requires a significant showing of illness before inpatient treatment is permitted. The “least restrictive alternative” standard requires that there are no less-restrictive alternatives to inpatient care.²³⁵

232. *In re Roger S.*, 569 P.2d 1286, 1289 (Cal. 1977).

233. CAL. WELF. & INST. CODE § 6002.30(c) (West, WESTLAW through 1997 portion of 1997-98 Reg. Sess. and 1st Ex. Sess.).

234. *Id.*

235. While *Roger S.* suggested that the “least restrictive alternative” standard might apply, the opinion never clearly articulated that this standard applied in the case. Instead, the opinion only noted that “the [U.S.] Supreme Court has suggested that a court may have a duty to explore possible alternatives to the involuntary commitment of a juvenile” 569 P.2d at 1292. Since *Roger S.* legislation has never been adopted, only counties which use LPS procedures as their means of enforcing *Roger S.* are likely to use the “least restrictive alternative” standard. It is unclear how likely this is given that the “least restrictive alternative” standard only applies when a conservator is appointed under California Welfare and Institutions Code § 5350 (West 1984).

For private placements, despite the presence of “least restrictive alternative” language in the California Welfare and Institutions Code § 6002.30(c) (West, WESTLAW through 1997

Potential inpatient admissions of gay minors based on GID, ODD or depression are troubling. Given the controversial nature of the diagnosis and treatment of GID,²³⁶ commitment based solely upon a diagnosis of GID should not be permitted.²³⁷ Even among those practitioners who believe that GID is treatable, the preferred treatment options are therapy or behavior modification, generally on an outpatient basis.²³⁸ While inpatient treatment is mentioned as a treatment option for GID in adolescents, it is thought to be an unrealistic option.²³⁹ Similarly, ODD or other similar diagnoses are quite controversial.²⁴⁰ Such diagnoses can easily be used to "label" gay minors as mentally ill without assessing whether there is a serious illness for which inpatient care is necessary.²⁴¹ The diagnosis of depression can be manipulated in a similar manner. While some gay minors suffer from depression, and need treatment, inpatient care is not necessarily the best way to treat it.

portion of 1997-98 Reg. Sess. and 1st Ex. Sess.), its usefulness is suspect. First, the statute uses "or," not "and," in its delineation of review criteria, providing alternative rather than cumulative standards. Arguably, the reviewing psychiatrist could make sufficient findings to support inpatient care if he finds that the minor continues to have a mental disorder even if inpatient care is not the least restrictive alternative. Second, the statute couples the "least restrictive alternative" with "availability." Thus, if no other alternatives exist, inpatient care can be deemed appropriate.

236. See *supra* notes 134-47 and accompanying text.

237. The literature suggests that GID is rare. See Beach, *supra* note 140, at 631. This seems to be born out in the OSHPD and S.B. 595 data. The OSHPD data for 14-17 year olds showed that nine children in 1990 and eight children in 1995 were admitted to inpatient care with a primary or secondary diagnosis of GID. GID is not an available diagnosis for children 13 years old and under, so it is difficult to determine whether there are any admissions because of GID or similar diagnoses. For the S.B. 595 data for 1995, only 1 of 2127 diagnoses was for a sexual disorder.

238. See *supra* notes 138, 139, 146, 147.

239.

In those cases in which a complete reversal of cross-gender behaviors and fantasies has apparently occurred, that reversal has been achieved by means of intensive (usually residential) long-term treatment employing behavior modification and insight-oriented psychotherapy (cites omitted) . . . However, given changes in sensibility regarding treatment choice, adolescents with gender identity disorder who are competent enough to make these decisions are unlikely to accept residential treatment for their condition. In fact, there have been no reports of such treatment over the last 10 years.

KENNETH J. ZUCKER & SUSAN J. BRADLEY, GENDER IDENTITY DISORDER AND PSYCHOSEXUAL PROBLEMS IN CHILDREN AND ADULTS 316 (1995). This quote contradicts the anecdotal stories related *supra* note 212. See also Robert J. Kosky, *Gender-Disordered Children: Does Inpatient Treatment Help?*, 146 MED. J. AUSTL. 565, 565-69 (1987) (reporting "good" short-term (ceasing or diminishing cross-gender behaviors) and longer-term outcomes (only one of the eight children reported post-pubertal homosexual feelings; none was transvestite or transsexual) among eight children admitted to the psychiatric unit of a hospital where no concerted behavior modification directed at cross-gender behavior was engaged in).

240. See *supra* notes 159-63 and accompanying text.

241. See *supra* note 165 and accompanying text.

For gay youth, if both the “gravely disabled or substantial risk of injury” and the “least restrictive alternative” standards are imposed, it will be difficult to justify inpatient care if the underlying diagnosis is GID, ODD, mild depression or some other similar diagnosis. None of these diagnoses is likely to meet the “gravely disabled or substantial risk of injury” standard. Moreover, for most minors, treatment, if any, would best occur on an outpatient basis.

B. Development of Treatment Alternatives

In order for the “least restrictive alternative” standard to be meaningful, alternatives to inpatient treatment must be developed. As it becomes more difficult to commit adolescents when it is not appropriate, pressure will increase to develop alternatives. As an example, a New Jersey study was cited in an amicus brief filed in *Parham*.²⁴² The study supported the notion that individualized treatment results can be obtained in cases where an advocate represented the child in pre-commitment hearings.²⁴³ The amicus brief summarized the results in 209 cases in which representation was provided to juveniles in commitment cases.²⁴⁴ All commitment decisions, whether made by parents or the State, or voluntarily by the juvenile, were reviewed.²⁴⁵ In approximately a third of the cases, commitment was ordered or permitted to continue.²⁴⁶ In another 18% of the cases, the minor’s voluntary application for admission was allowed.²⁴⁷ In just over 20% of the cases, the minors were released to alternative placements.²⁴⁸ Thus, in a significant number of cases, alternatives to inpatient treatment were arrived at through the efforts of the collaboration of the advocacy and medical teams.²⁴⁹

For gay youth in particular, current treatment alternatives which serve their unique needs are few and far between, and information about

242. See Brief of Amicus Curiae, Dept. Pub. Advocate, Div. of Mental Health Advocacy, State of N.J. at 2, 18, 19, *Parham v. J.R.*, 442 U.S. 584 (1979).

243. *Id.* at 18-28.

244. *Id.* at 19 & n.21.

245. *Id.* at 10-11.

246. *Id.* at 19-21.

247. *Id.* at 20-21.

248. *Id.* at 19-20.

249. *Id.* at 18-21. In twenty-two cases (10.5%) commitment was ordered, and in thirty cases (14.4%), commitment was permitted to continue. In thirty-eight cases (18.2%), voluntary applications for admission were accepted. In forty-four cases (21.1%), the juvenile was released to an alternative placement (other than an inpatient placement) of varying sorts. In five cases, the juveniles were either transferred to an out-of-state hospital or to a special education program while institutionalized; five were remanded to jails or youth detention facilities. In the remaining sixty-five cases (31.1%), juveniles were discharged either prior to a hearing, or after the hearing.

existing options is scarce. Studies have shown that the most effective "treatment" for gay youth is alleviating the social isolation which they experience.²⁵⁰ When gay youth have the opportunity to participate in peer support groups, they benefit greatly.²⁵¹ Because of the lack of treatment options or the lack of awareness of such options, they may actually opt for inpatient care instead of staying with their families or being out on the street. If other alternatives are developed, it is more likely that the gay youth will not be pushed into inappropriate commitments.²⁵²

C. Right to Representation

Appointment of counsel is mandated for LPS wards and *Roger S.* claimants.²⁵³ There is no right to counsel during S.B. 595 reviews.²⁵⁴ In order for adolescents to make informed decisions when faced with possible commitment, they must have access to information about options, including treatment alternatives. In addition, they need to be able to make decisions under the least coercive circumstances possible. For gay youth in particular, this will best be accomplished if representation of counsel is required. If counsel is provided, all options, including inpatient treatment, can be discussed and considered. More importantly, decisions can be made without the potentially coercive influence of parents and medical personnel.

The New Jersey study indicated that in most cases parents were pleased with the involvement of counsel, including several parents whose opinions changed from negative to positive during the course of the representation.²⁵⁵ The amicus brief also indicated that "the presence of counsel has led to exceptional judicial creativity in an area in which, most likely, such creativity would be conspicuously absent but for the presence of an adversarial role."²⁵⁶

250. John Gonsiorek, *Mental Health Issues of Gay and Lesbian Adolescents*, 9 J. ADOLESCENT HEALTH CARE 114, 120 (1988).

251. *Id.*

252. Other options such as enabling gay or gay-friendly families to serve as foster families must be developed. See Polikoff, *supra* note 72. In addition, health care providers and teachers need to be educated about lesbian, gay, bisexual, transgender, and questioning youth issues so that they can respond appropriately when they interact with such youth dealing with developmental issues.

253. See *supra* notes 21, 40.

254. See *supra* note 67.

255. Amicus Brief, *supra* note 242, at 23.

256. *Id.* at 25.

D. Prohibitions Against Uninformed Waivers

Roger S. and S.B. 595 claimants must affirmatively invoke due process rights in order to obtain the respective review process. It is ironic that while courts attribute to children an inability to make good decisions for themselves, they permit children to “waive” their due process rights by simply failing to invoke them. *Roger S.* seemed to acknowledge this when it noted the suggestion that

a waiver of a minor should not be accepted unless accompanied by a certificate of his counsel attesting that the attorney has consulted with the minor about the proposed commitment, explained his right to protest it, described possible alternatives and ascertained that the minor wished to enter the hospital without a hearing.²⁵⁷

As noted earlier, S.B. 595 data indicated that 54% of the minors who requested independent clinical reviews withdrew their request.²⁵⁸ With representation, it is quite likely that a number of the commitments could be challenged successfully, given the high release rate also shown by the data.²⁵⁹ The New Jersey survey indicated that in just over 30% of the cases in which reviews were conducted the minor was discharged, either prior to or after the hearing.²⁶⁰ Another 21% of the minors went to alternative placements.²⁶¹ The preliminary data cited by CAMPHRA also indicated significant differences between more formal *Roger S.* reviews and the informal reviews under S.B. 595.²⁶²

As in the New Jersey system, all commitment decisions should be reviewed, whether “voluntary” or not. This way, the court can make a determination as to whether the “waiver” of rights is an informed and competent one.

E. Meaningful Forums for Consideration of Alternatives

It is unclear what commitment review process best meets the needs of gay youth. In LPS cases, an automatic certification or petition review occurs if commitment beyond the initial seventy-two hours is sought.²⁶³ In addition, habeas petitions requiring a court or jury trial can also be filed to challenge commitment or conservatorship petitions.²⁶⁴ *Roger S.* reviews, as actually implemented on a county-by-county basis, take sev-

257. *Roger S.*, 569 P.2d at 1296 n.10.

258. See *supra* note 229 and accompanying text.

259. See *id.*

260. See *supra* note 249 and accompanying text.

261. See *id.*

262. See *supra* notes 223, 224.

263. See *supra* note 20.

264. See *supra* note 21.

eral different forms, but at a minimum require a pre-commitment hearing (which need not be judicial), and a neutral and detached decision-maker.²⁶⁵ The S.B. 595 procedures require a post-commitment independent clinical review conducted by a disinterested psychiatrist.²⁶⁶

It is clear that the protections in the private placement process need to be strengthened. The current system depends upon self-regulation for which there is little oversight. The dismal compliance rate with the reporting requirement demonstrates, at best, indifference to the concerns reflected in the statute, or at worst, active disregard for the rights of minors. The current independent clinical review does not address the unique concerns of gay children because there is nothing built into the review system to ensure, for example, that the controversial nature of the GID or ODD diagnoses will be considered.

Alternatively, new forums should be considered and implemented. Team reviews similar to those which occur in the New Jersey system could be adopted. Multi-disciplinary teams could review the commitment recommendation and consider alternatives.²⁶⁷ Other creative dispute resolution methods should be explored. For example, a mediation alternative should be examined.

F. Need for Additional Data, Research, and State Enforcement

In evaluating alternative procedures, it would be useful to have additional data and research. To this end, several avenues of data collection and research should be pursued.

A starting point is an examination of release rates, that is, the rate of successful challenges to commitment decisions. Studies similar to the one conducted in New Jersey could be conducted for minors who are committed through LPS, *Roger S.*, and S.B. 595 procedures. These studies could analyze rates at which reviews are requested, release rates, and the types of placements, other than inpatient admission, with which the minors are provided.

Second, the S.B. 595 reporting requirement must be enforced. The reporting requirement applies to "mental health facilities" where the service is paid for by a private insurer or private health services plan.²⁶⁸

265. See *supra* notes 40, 41.

266. See *supra* note 64.

267. See Weithorn, *supra* note 121, at 832.

268. CAL. WELF. & INST. CODE § 6002.40(b), (c) (West, WESTLAW through 1997 portion of 1997-98 Reg. Sess. and 1st Ex. Sess.). "Mental health facilities" is not defined in this statutory section, but California Welfare and Institutions Code § 5500(c) (1984) defines "mental health facilities, services or programs" as "any publicly operated or supported mental health facility or program; any private facility or program licensed or operated for health purposes providing services to mentally disordered persons; and publicly supported agencies providing

It is disturbing that of 10,457 total admissions involving a psychiatric diagnosis, only 2127 admissions are accounted for in S.B. 595 reports submitted to DMH.²⁶⁹ It is also disturbing that only 11 facilities reported S.B. 595 data, while there were 378 different facilities submitting discharge data with at least one psychiatric diagnosis.²⁷⁰ Since fewer procedural protections are provided to minors whose parents seek to admit their children to private hospitals, and given the potential for economically, rather than treatment, driven decisions in private settings, the potential for abuse is high.²⁷¹ This data gives the only available insight into the effectiveness of the S.B. 595 review system. The reporting requirement provides the only current oversight protection governing the S.B. 595 review system and therefore compliance must be compelled. This will require the legislature to allocate additional funds to DMH. DMH could then be directed to develop regulations ensuring compliance with the statutory requirements.

Conclusion

Due process protections for gay youth in the commitment process should be strengthened to reflect developments in the law, changing societal attitudes toward sexual orientation and children, and controversial psychiatric diagnoses and treatment. While additional research would clarify the effectiveness of various approaches, at a minimum, the admission standard should be strengthened, a review should be mandatory in all cases, and youth should have a right to representation.

Gay youth are a particularly vulnerable segment of our society, but many of the arguments here apply with equal force to children in general. Greater and greater numbers of children face institutionalization—not only in terms of inpatient psychiatric admissions, but to the child welfare system and juvenile justice systems, as well. All of these children need protections to ensure that decisions are made to improve their lives and solve underlying problems, rather than make them worse.

other than mental health services to mentally disordered clients.” Applying this definition to the S.B. 595 reporting requirement, all of the facilities which reported discharge data, except for county hospitals, should have reported data to DMH.

269. See *supra* notes 223, 229 and accompanying text. Discharge records were sorted according to expected payment source. The 10,457 admissions represent all admissions for which the expected payment source was one of the following: HMO, PPO, Private Insurance Company (not HMO, not PPO), or Blue Cross/Blue Shield (not HMO, not PPO). These payment sources all come within the ambit of California Welfare and Institutions Code § 6002.40(b), (c) (West, WESTLAW through 1997 portion of 1997-98 Reg. Sess. and 1st Ex. Sess.) and should be accounted for by S.B. 595 reports.

270. See *supra* notes 223, 229. Only those facilities which reflected at least one admission in which the expected payment sources were private insurers or private health services plans were included.

271. See *supra* Part II.C.3.

Dear Desperate, continued:

I hope that you never have to face being committed by your parents. If you do, I hope you understand what your rights are and that in California you can challenge your parents' decision. You should also know that there are people who think that commitments shouldn't happen when the reason is a child's sexual orientation. I hope that these people are successful at changing the law so that it better protects kids like you.

I wish you the best of luck.